2006

Comprehensive Performance Report: Commercial HMOs and Their POS Plans in Maryland

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INTRODUCTION

Overview

The Maryland Health Care Commission (MHCC) is committed to assessing and reporting on the performance of Maryland commercial health maintenance organizations (HMOs) and point of service (POS) plans. The *Comprehensive Performance Report: Commercial HMOs and Their POS Plans in Maryland (Comprehensive Report)* is MHCC's tenth annual report on the performance of HMOs operating in Maryland, which provides plans, providers, researchers, and other interested individuals with detailed, plan-specific and Maryland-wide indicators of performance.

This year's *Comprehensive Report* incorporates data collected in 2006 using the Health Plan Employer Data and Information Set (HEDIS®[1]) measurement tool, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) 3.0H survey, and results for 2004 and 2005. The performance measures in this report cover clinical quality, member satisfaction, plan descriptive features, and utilization information. Eight new HEDIS measures have been included to assess quality of care in several critical areas and address conditions such as chronic obstructive pulmonary disease (COPD), arthritis, medication management, patient safety, and attention deficit/hyperactivity disorder (ADHD). Additionally, results for measures specific to Maryland are also included in this report. All of the measures presented are important indicators of the quality of health provided to Marylanders.

Reporting multi-year performance builds a stronger depiction of how a plan carries out health care delivery. Single-year results provide a snapshot and should be viewed in that context. Results tables included here illustrate changes in plans' absolute (actual) rates and relative (comparative) rates. Additionally, MHCC conveys "Star Performer" designation to acknowledge dedication to quality health care delivery by plans that achieve rates statistically higher than the Maryland average for the three recent reporting years (2004–2006).

The *Comprehensive Report* is designed to help plans, purchasers, and policymakers assess the relative quality of services delivered by plans licensed to operate in Maryland. Such information has the capacity to affect purchasing and enrollment decisions, marketplace changes, and quality initiatives implemented by commercial HMOs and POS plans.

Report Organization

The *Comprehensive Report* organizes measurement results into groups, or domains, of related information. The sequence of measures within the domains is similar to the order of the measures identified in *HEDIS 2006, Volume 2: Technical Specifications.* Maryland plans followed the technical specifications in developing their rates.

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Plans are listed alphabetically in tables that display their rates and the average rate for all Maryland plans for HEDIS, the CAHPS 3.0H survey, and MHCC-specific measures of performance.

The *Comprehensive Report* progresses from a summary of plans' performance into detailed results for each measure. Sections are as follows.

- **Summary of Performance** provides an overview of the Maryland marketplace and the performance of the plans required to report to MHCC.
- **Methodology** covers data sources, statistical methods, and general considerations for interpreting the data in this report.
- **Measure Performance** provides the following for each measure.
  - **Background** information describing a measure's importance and any relevant clinical or population health information
  - **Measure definition** consistent with *HEDIS 2006, Volume 2: Technical Specifications*
  - **Data collection methodology** indicating if administrative, hybrid, or survey methodology was used to collect the measure
  - **Summary of changes to HEDIS 2006** listing the significant changes in measure specifications that may affect the ability to trend results
  - **Star Performer** identifying the measures eligible for the designation
  - **Notes** describing any considerations regarding production or interpretation of results (where applicable)
  - **Results** of plan rates and scores that identify salient results
  - **Data Table(s)** containing plan rates (i.e., percentages, rates per 1,000 members), significant changes in rates from 2004 to 2006, and relative rates (i.e., designation above, equivalent to, or below the Maryland HMO/POS average) for the past three years
- **External Accreditation & Financial Ratings** presents the accreditation status and financial rating of each plan. In Maryland, accreditation is voluntary (i.e., not required by law). Information on the various organizations that accredit managed behavioral healthcare organizations (MBHO) is included in this section, as well. The material presented in this section concludes with ratings reported by A.M. Best on plans' financial stability.
- **Appendix A: Health Plan Performance by Measure** sorts plan results by score for each measure to show which plans performed best in each.
- **Appendix B: Methods for Data Analyses** describes the methodology used to compare plan performance and rates across years for HEDIS and CAHPS 3.0H survey measures.

- **Appendix C: Methodology for Audit of HEDIS 2006 Rates for Maryland HMOs and POS Plans** summarizes the 2006 audit methodology used to verify that Maryland health plans followed the specifications of the NCQA HEDIS Compliance Audit™[3] when they calculated rates for each measure.
- **Appendix D: Methodology for Administering CAHPS 3.0H Survey for Maryland HMOs and POS Plans** summarizes the survey methodology used to collect and calculate the CAHPS 3.0H 2006 survey results.

MHCC-specific measures are included in the *Behavioral Healthcare* and *Effectiveness of Care* sections. They are part of the set of mandatory performance measures that commercial HMOs in Maryland were required to report in 2006.

Companion Maryland HMO and POS Performance Reports

Measuring the Quality of Maryland HMOs and POS Plans: 2006 Consumer Guide provides a subset of measures selected for their interest to employers and consumers.

Measuring the Quality of Maryland HMOs and POS Plans: State Employee Guide, spring edition, presents the same content and format as the *2006 Consumer Guide,* but includes only HMOs and POS plans available to employees of the State of Maryland.

In January 2007, MHCC will release the tenth annual *Maryland Commercial HMOs & POS Plans: Policy Issues.* This report summarizes the aggregate performance of Maryland plans and compares it to commercial plans in the region and nation.

Other MHCC Performance and Facility Reports

MHCC produces the *Maryland Nursing Home Performance Evaluation Guide,* which contains comparative data that consumers can use to evaluate Maryland nursing homes. The *Hospital Performance Evaluation Guide* is another MHCC-published, interactive guide that features descriptive information and quality measurement results on the performance of Maryland's acute care hospitals. MHCC also produces the *Maryland Ambulatory Surgery Facility Consumer Guide,* which allows consumers to compare descriptive information about these facilities and their services. The *Maryland Home Health Agency Statistical Profile* report summarizes data on the utilization and financing of home health services. All of the guides are accessible through the MHCC Web site at http://mhcc.maryland.gov.

[3]HEDIS Compliance Audit™ is a trademark of NCQA.

Quality Evaluation and Reporting

Health General Article, Section 19-135 (c) charges the Maryland Health Care Commission with establishing and implementing a system to comparatively evaluate the quality of care and performance of HMOs on an objective basis. The purpose of the system is twofold.

1. Assist HMOs in improving quality of care by establishing a common set of performance measures.
2. Disseminate the findings of the performance measures to consumers, purchasers, HMOs, and other interested parties.

SUMMARY OF PERFORMANCE

SUMMARY OF PERFORMANCE

This section provides an overview of trends in the managed care market and a summary of performance by the Maryland commercial HMOs required to report in 2006.

Health Care Trends

- Nationally, health care premiums increased an average of 9.2% in 2005, down from 11.2% in 2004. Despite this drop, the 2005 increase is still more than three times the 2.7% growth in workers' earnings, and two-and-a-half times the 3.5% rate of inflation (Kaiser Family Foundation and the Health Research and Educational Trust, 2005).
- With the rate of increase of health care costs outpacing that of growth in wages and other business expenses, more employers are stepping up their cost-containment efforts. Employer strategies range from educational efforts to creative cost-sharing methods.
  - Educating employees on becoming better health care consumers
  - Promoting employee health
  - Employee cost-sharing
- Health information technology (HIT) is broadly thought of as using computers to store, retrieve, and share health information, data, and other information needed for decision making. The spiraling cost of health care, as well as serious concerns about preventable medical errors, inconsistency in the quality of care, and fragmented communication among health care providers involved in treating patients, have all emerged as key drivers toward wider adoption and use of HIT.
- Health care efficiency and affordability have emerged as major issues with both employers and health plans pushing for better access to data. There is great demand for information to help purchasers and consumers determine which plans offer the highest quality services, along with effective management of services, and low premium or out-of-pocket costs. In 2007, HEDIS will include, for the first time, measures for assessing resource use among members with chronic and acute conditions. When coupled with HEDIS quality of care measures, the three resource use measures are intended to provide information about the *efficiency* or *value* of services rendered by a health plan.
  - Relative Resource Use for People with Diabetes
  - Relative Resource Use for People with Asthma
  - Relative Resource Use for People with Acute Low Back Pain

Maryland Health Plans in this Report

This report includes HMOs that primarily serve the commercially insured population and receive over 1 million dollars in Maryland premiums. Each plan has the option of reporting combined performance results for its HMO and POS products, but only if the POS plan operates under the license of its HMO. Each plan (with the exception of Kaiser Permanente) has chosen that option. **References to HMOs and HMO members throughout this report should be understood to include POS members for six of the seven plans.** The number of plans reporting to MHCC remained the same for 2005 and 2006.

Table 1 shows the total number of members enrolled in each plan, the percentage of members who enrolled in the plan's HMO product, and the percentage of members who enrolled in the plan's POS product. POS products tend to cost more, which may explain why fewer people selected the POS product.

Table 1: Maryland Health Plan Enrollment, 2005

Health Plan	Number of Plan Members	% of Members Enrolled in HMO	% of Members Enrolled in POS
Aetna Health Inc.-Maryland, DC, and Virginia **(Aetna)**	312,769	86%	14%
CareFirst BlueChoice, Inc. **(BlueChoice)**	560,134	57%	43%
CIGNA HealthCare Mid-Atlantic, Inc. **(CIGNA)**	279,805	66%	34%
Coventry Health Care of Delaware, Inc. **(Coventry)**	98,903	88%	12%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. **(Kaiser Permanente)**	443,566	96%	4%
MD-Individual Practice Association, Inc. **(M.D. IPA)**	234,488	85%	15%
Optimum Choice, Inc. **(OCI)**	504,786	85%	15%

Below is a brief overview of the plans' operating structures.

- **Aetna** and **CIGNA**, for-profit HMOs, and **Kaiser Permanente**, the only non-profit HMO operating in Maryland, represent national health care insurers in Maryland.
- **BlueChoice,** a for-profit HMO, operates under a holding company called CareFirst.
- **Coventry,** a for-profit HMO, is a regional company.
- **M.D. IPA** and **OCI**, for-profit HMOs, are owned and operated by Mid Atlantic Medical Services, LLC (MAMSI), a regional holding company and subsidiary of UnitedHealth Group, Inc.

One-Year Above-Average Performance

Table 2 displays the number of instances by domain where each plan had above-average scores. Based on reported rates used to calculate 2006 rankings, plans have the potential to achieve above-average rankings on 45 HEDIS and 8 CAHPS measures. Kaiser Permanente received the most above-average scores, achieving this level for 27 (51%) of the measures. BlueChoice followed with 17 above-average scores and then CIGNA with 13 above-average scores. Coventry followed with 10 above-average scores, then M. D. IPA with 8 above-average scores. Aetna received 5 above-average scores, while OCI had 4 above-average scores.

As a general rule, composite rankings have been used to summarize plans' performance; therefore, the number of eligible measures is sometimes less than the number of total measures in each domain. Results for the individual measures in a composite are excluded from a plan's total count. For example, the *Childhood Immunization Status (Combination 2)* measure counts as one measure; the results for each antigen are not counted individually.

Table 2: Total Above-Average Scores by Plan

Total Above Average Scores by Plan, 2006								
	Effectiveness of Care	Access/ Availability of Care	Behavioral Health	Health Plan Descriptive Information	Health Plan Stability	Total HEDIS	Total CAHPS	Total HEDIS & CAHPS
Total Number of Measures in Each Domain:	24	9	7	4	1	45	8	53
Aetna	1	2	1	0	1	5	0	5
BlueChoice	4	7	3	1	0	15	2	17
CIGNA	6	3	0	3	1	13	0	13
Coventry	1	6	0	1	1	9	1	10
Kaiser Permanente	16	4	3	3	0	26	1	27
M.D. IPA	4	2	1	0	0	7	1	8
OCI	1	0	2	0	0	3	1	4

See *Appendix A: Health Plan Performance by Measure* for the measures that are included in each domain.

Three-Year Above-Average Performance—Star Performers

Table 3 shows the number of times and measures for which a plan achieved Star Performer designation in 2006. The "Star Performer" designation is given to plans that have maintained above-average performance on a particular measure for each of the past three years. Plans could potentially achieve this status for 23 measures: 16 HEDIS and 8 CAHPS measures. Only measures reported in *Measuring the Quality of Maryland HMOs and POS Plans: 2006 Consumer Guide* are eligible for this designation. In 2006, BlueChoice, CIGNA, Coventry, Kaiser Permanente, and M.D. IPA received at least one Star Performer designation. Kaiser Permanente achieved this status for 40% of the eligible measures. Two plans—Aetna and OCI—did not achieve Star Performer status. For more information on the measures that qualify for Star Performer designation, see the *Methodology* section.

Table 3: Star Performers by Plan

Plan	Number of Star Performer Designations	Measures for which Plan Achieved Star Performer Status
Aetna	0	
BlueChoice	1	• Well-Care Visits for Adolescents
CIGNA	2	• Well-Child Visits for Infants and Children • Controlling High Blood Pressure
Coventry	4	• Getting Care Quickly • Well-Child Visits for Infants and Children • Well-Care Visits for Adolescents • Screening for Breast Cancer
Kaiser Permanente	5	• Immunizations for Children • Immunizations for Adolescents • Screening for Chlamydia • Comprehensive Diabetes Care – Eye Exams – Monitoring for Kidney Disease
M.D. IPA	3	• Health Plan Customer Service • Screening for Colorectal Cancer • Antidepressant Medication Management Treatment (Optimal Contacts)
OCI	0	

Note: *Measure names used in the above table correspond to those used in the Consumer Guide. Measure names used elsewhere in the Comprehensive Report correspond to those used in HEDIS Volume 2: Technical Specifications.*

METHODOLOGY

METHODOLOGY

This section describes the data and statistical methods used to determine relative plan performance, the statistical significance of trends, and the criteria used to identify Star Performers. In addition, general considerations regarding interpretation of data contained in this report address factors with the potential to affect plan results.

Data Sources

Data reported in the *Comprehensive Report* are drawn primarily from two sources: the Health Plan Employer Data and Information Set (HEDIS®) performance measures and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 3.0H survey. To satisfy legislative, task force, and MHCC requirements, plans report on several measures of performance specific to Maryland, referred to as "MHCC-specific" measures.

HEDIS Measures

HEDIS is a standard set of performance measures developed by NCQA and experts representing many fields. NCQA is a not-for-profit organization that assesses, accredits, and reports on the quality of managed care organizations (MCOs), including health maintenance organizations (HMOs).

Rates reported for HEDIS 2006 measures reflect services delivered during the 2005 calendar year (CY). Similarly, 2005 and 2004 results presented in this report for trending purposes reflect performance experiences from CY 2004 and CY 2003, respectively.

Based on Maryland's information needs and expectations regarding data reliability, The Maryland Health Care Commission required that plans report 45 HEDIS measures for CY 2005. Several measures required collecting multiple rates; for example, the *Childhood Immunization Status* measure has two combinations of recommended immunizations, thereby resulting in two separate rates for one measure. In addition, Maryland plans were asked to provide specific data and information about their behavioral health services.

This report presents results collected from seven Maryland plans in seven general areas.

1. Effectiveness of Care
2. Access/Availability of Care
3. Satisfaction with the Experience of Care (CAHPS 3.0H Adult Survey)
4. Use of Services
5. Behavioral Healthcare
6. Health Plan Descriptive Information
7. Health Plan Stability

All HEDIS measures collected by plans for MHCC have been audited according to the certified audit program established by NCQA. The NCQA HEDIS Compliance Audit is a standardized methodology that enables organizations to directly compare plan results for

HEDIS performance measures. The audit is a two-part process and consists of an assessment of overall information systems capabilities followed by an evaluation of the plan's ability to comply with HEDIS specifications. HealthcareData.com, LLC, independently audited data displayed throughout this report under a separate, competitively-bid contract with the MHCC. See Appendix C for more information regarding the audit process.

Data Collection Methodology

For many measures, HEDIS gives plans the choice of administrative or hybrid data collection methodology. The hybrid methodology allows health plans to supplement rates calculated from administrative data systems with information from members' medical records. By using this method, health plans can produce rates that better reflect actual performance. The majority of the measures eligible for the hybrid rate collection methodology are in the *Effectiveness of Care* domain with the exception of the *Prenatal and Postpartum Care* and *Well-Child Visit* measures, which are in the *Access/Availability of Care* and *Use of Services* domains, respectively. Several measures in the *Effectiveness of Care* domain allow only administrative collection of the rates: *Breast Cancer Screening, Use of Appropriate Medications for People with Asthma, Follow-Up after Hospitalization for Mental Illness, and Antidepressant Medication Management* measures.

Briefly, the two methodologies entail the following steps.

- ***Administrative methodology:*** After identifying the eligible member population for a measure, health plans search their administrative database (claims and encounter systems) for evidence of the service. For some measures, rates calculated using the administrative method might be slightly lower than rates calculated for the same measure using the hybrid method. Plans might choose this method because it is easier to produce rates.

  In the result tables for hybrid-eligible measures, plans that use only administrative data to generate rates are indicated by a superscript "m."

- ***Hybrid methodology:*** The hybrid methodology allows health plans to augment their HEDIS calculations with information gathered from medical records. After selecting a random sample of eligible members for a measure, the health plan searches its administrative databases for information about whether each individual in the sample received the service. If the administrative database does not contain the information, the plan consults the medical records next for evidence that individuals in the sample received the service.

Rotation of Measures

NCQA allows health plans to *rotate* data collection for selected HEDIS measures. For rotated measures, data may be collected once and reported for two consecutive years. The measures that NCQA selects for rotation are those that impose a substantial burden for health plans to collect and have been part of the HEDIS measurement set for at least two years, and for which no significant changes have been made on how data are collected and reported.

If a health plan rotates a measure, valid results reported to MHCC in 2005 are also shown as 2006 results in this report. Table 4 indicates the measures eligible for rotation and the measures each plan rotated.

Table 4: Rotated Measures

		Measures Eligible for Rotation							
				Comprehensive Diabetes Care					
Health Plan	Number of Measures Rotated by Plan	Cervical Cancer Screening	Controlling High Blood Pressure	Blood Glucose (HbA1c) Testing and Control	Cholesterol (LDL-C) Testing and Control	Eye Exams	Monitoring Diabetic Nephropathy	Prenatal Care	Postpartum Care
Aetna	3	Yes		Yes					Yes
BlueChoice	4		Yes			Yes	Yes		Yes
CIGNA	0								
Coventry	8	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kaiser	6			Yes	Yes	Yes	Yes	Yes	Yes
M.D. IPA	4	Yes		Yes				Yes	Yes
OCI	4	Yes		Yes				Yes	Yes

Plans that rotate the measure are identified by a superscript "r" in the result tables.

Not Report and Not Applicable Designations

Plans must report a rate for each measure included in the MHCC's performance reporting set and do not have the option of choosing not to calculate or not report rates for these measures; therefore, each *Not Report (NR)*[1] designation that appears in the Maryland HMO performance reports means the plan did not pass the audit for that measure.

When a plan can accurately generate a rate but the denominator (the number of members who meet criteria for a measure) is less than 30, its rate is reported as *Not Applicable (NA)*. NCQA guidelines set 30 as the lower acceptable limit for denominators. When fewer than 30 people constitute the population undergoing comparison, statistical validity and the measure's meaningfulness becomes questionable.

[1] According to NCQA guidelines, measures are assigned a *Not Report (NR)* designation if they meet the following criteria: 1) The plan did not calculate the measure and a population existed for which the measure could have been calculated; 2) The plan calculated the measure but chose not to report the rate; or 3) The plan calculated the measure but the rate was materially biased. For measures reported as a rate (e.g., *Effectiveness of Care*) and for the three service measures, "materially biased" is an error that causes a ±5 percentage point difference in the reported rate. For nonrate measures (e.g., *Use of Services* and survey measures), materially biased is an error that causes a ±10 percent change in the reported rate.

CAHPS 3.0H Survey Measures

The *Satisfaction with the Experience of Care* section of this report contains survey results from health plan members. The CAHPS 3.0H survey (included in the HEDIS measurement set) has been administered to randomly selected samples of Maryland commercial HMO members each year since 1999.

Various versions of the CAHPS survey have been created—adult and child and product-specific surveys for commercial, Medicaid, and Medicare health plan members. All versions of the survey contain question sets covering such topics as enrollment and coverage, access to and utilization of health care, communication and interaction with providers, interaction with health plan administration, self-perceived health status, and respondent demographics.

MHCC contracted with The Myers Group to administer the CAHPS 3.0H survey to the adult, commercial HMO population. The Myers Group is an NCQA-Certified CAHPS 3.0H survey vendor. A random sample of 1,100 members from each health plan was surveyed in 2006. The survey was administered according to the protocol outlined by NCQA in *HEDIS 2006, Volume 3: Specifications for Survey Measures*. See Appendix D for additional information regarding survey methodology.

Statistical Analysis

Calculation of Relative Rates

All plans contributed equally to the average rate of performance; i.e., the average rate was determined by adding the rate for each plan and dividing by seven. Then individual plan rates were compared to the unweighted average rate of performance for all seven Maryland plans and assigned a performance rating classification of "above average," "average," or "below average" for each process measure. If the difference between the plan's rate and the Maryland HMO/POS average was statistically significant, the plan was assigned to the above- or below-average category, accordingly. To determine the statistical significance of differences between the two values, analysis using a modified t-test was conducted to account for potential errors in measurement of the individual plan's rate, as well as potential errors in measurement of the Maryland HMO/POS average. A 95 percent degree of confidence was then used to determine whether the difference between the rates was statistically significant. See Appendix B for a detailed description of this methodology.

The tables in this report use the following symbols to denote relative comparisons,

★★★ = The plan performed significantly better than the Maryland HMO/POS average

★★ = The plan performed equivalent to the Maryland HMO/POS average

★ = The plan performed significantly worse than the Maryland HMO/POS average

In some situations, two plans with the same rate can be classified into two different performance rating categories as a result of the data collection methodology used by the plan. Plans that use the administrative method to calculate a rate tend to have smaller confidence intervals around their rates because the entire population eligible for the measure is used as the measure denominator rather than a sample. A larger denominator allows more precision estimating the true rate. In statistical terms, the confidence interval around the rate is smaller. *This means that two plans with the same percentage can be in two different performance strata.* For example, Plan A and Plan B both report a rate of 85% for a given measure. The Maryland HMO/POS average for this example is 80%. Plan A used the hybrid method and, due to its larger confidence interval, its performance is designated as "average" when compared to the state average for all seven plans. Plan B used the administrative method and its performance is designated as "above average," since its narrower confidence interval excludes the Maryland HMO/POS average. Additionally, plans with the same rate could be designated as performing at two different levels because **statistical tests were conducted using entire numbers without rounding**. Rates were rounded for display in this report.

Understanding Data Comparisons and Changes from 2004 to 2006

Comparisons over time provide an assessment of the quality of services offered by plans and an opportunity to look at trends toward improved performance. The trending tables contain a column titled "Change 2004–2006," which indicates if a change in a plan's actual rate from 2004–2006 is statistically significant and, if so, the direction of the change. It is an indicator of the consistency of a plan's performance over time rather than its performance in relation to other plans.

The tables use the following symbols.

↑ = Plan rate increased significantly from 2004 to 2006

⇔ = Plan rate *did not* change significantly from 2004 to 2006

↓ = Plan rate decreased significantly from 2004 to 2006

This indicator shows whether a plan's actual rate has improved over time; it is independent of the plan's relative rating. To illustrate how this indicator differs from the relative rating indicator, a plan's rate may have changed from 65% in 2004 to 75% in 2006, a significant increase that would be identified with the "↑" symbol. However, it is possible for the relative ranking to remain unchanged or even decline if the Maryland HMO/POS average changed from 60% in 2004 to 80% in 2006. In this example, the plan's relative rating may have been above average in 2004 but below average in 2006 because of the upward shift in the Maryland HMO/POS average. Over time, the plan shows a statistically significant increase in its performance, but it increased less significantly than the Maryland HMO/POS average over the same period.

The three columns titled "Comparison of Relative Rates" show how each plan performed in relation to the other plans that reported each year. The relative score is an indicator of the plan's performance (above, average, or below average) relative to the Maryland HMO/POS average.

The term "significant" is used in the statistical sense. For example, a significant change in a plan's rate from 2004 to 2006 means that the change is very unlikely to have occurred due to chance variation, but it does not describe the magnitude of that change. A one percent change can be considered significant if the population on which it is based is large, as is often the case with HEDIS rates calculated using the administrative method.

Percentiles

NCQA annually releases Quality Compass®[2], which contains HEDIS rates and averages obtained from hundreds of HMOs across the country. These data are used to construct scores by quartile and for the top (90th percentile) and bottom (10th percentile) deciles. A score in the top decile is a score that is higher than the scores of at least 90 percent of the HMOs that report to Quality Compass; a score in the bottom decile is a score that is lower than the scores of at least 90 percent of the Quality Compass scores.

Rates and averages that are in the top and bottom deciles in the *Use of Services* section of this report are indicated by the following symbols.

▲ = The plan rate is higher than 90 percent of other plans nationally

▼ = The plan rate is lower than 90 percent of other plans nationally

Star Performers

To be considered a Star Performer for a specific measure, a health plan must maintain an above average level of performance for each of the past three years, as identified by the statistical significance test described in the previous section. Only measures reported in the *Consumer Guide* are considered for Star Performer designation.

Twenty-three measures (15 HEDIS and 8 CAHPS) were eligible for Star Performer status in 2006. The eligible measures follow.

HEDIS

- Childhood Immunization Status (Combination 2)
- Adolescent Immunization Status (Combination 2)
- Chlamydia Screening (Ages 16–25)
- Controlling High Blood Pressure
- Comprehensive Diabetes Care:
  - Eye Exam Performed
  - Monitoring for Kidney Disease
- Colorectal Cancer Screening
- Breast Cancer Screening
- Advising Smokers to Quit
- Well-Child Visits for Infants and Children: Combined age rate—Birth to 15 months and 3–6 years

[2] Quality Compass® is a registered trademark of NCQA.

- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness:
  - Thirty days after discharge
- Antidepressant Medication Management:
  - Treatment (Optimal Contacts)
  - Six months
- Initiation of Alcohol and Other Drug Dependence Treatment

CAHPS

- Rating of Health Plan
- Recommending Plan to Friends/Family
- Few Consumer Complaints
- Health Plan Customer Service
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Rating of Health Care

Star Performance is noted in the report's data tables by the following symbol: ★★★★. Refer to Table 3 ("Star Performers by Plan") in the *Summary of Performance* section for the consolidated list of measures designated as Star Performers for each plan.

General Considerations for Interpreting Information

Impact of Health Plan Consolidations

The same seven plans have reported to MHCC from 2004 to 2006. Since Maryland's quality reporting initiative began in 1997, a variety of plan mergers and consolidations have occurred. Most recently, CIGNA consolidated its Virginia and Mid-Atlantic networks and memberships (2005) and continues to do business under the name CIGNA HealthCare Mid-Atlantic, Inc. CIGNA has submitted its performance information to MHCC for the three-year period covered in this report. Results reported in 2006 include the experiences of the expanded membership.

Data Completeness

A plan may not have complete data on all of the services rendered to its members for reasons described below.

- In plan mergers or acquisitions, the surviving health plan must integrate all data from predecessor plans for future HEDIS reporting. Administrative data system conversions can be complex and can lead to loss of data. Even if a system conversion has not taken place, creating HEDIS measures from multiple systems can raise data integration issues that may lead to data loss.

- For some HMO providers, payment is capitated and is not associated with each service rendered to enrollees; therefore, providers may not always submit the encounter information to the HMO, even though care was provided.

- Many HMOs do not receive complete patient data from contractual vendors that provide services such as laboratory, radiology, pharmacy, and mental health services. Plans have improved data transfers from vendors, however, by implementing incentive programs and setting this requirement as part of their contracts.

These factors, along with the choice of administrative versus hybrid data collection methods, can cause underreporting or overreporting of HEDIS results that are not attributable to differences in performance. Although plans continually work to improve their data for use in performance measurement and quality improvement, demonstrating the effects of these factors on final HEDIS rates is extremely difficult.

Performance Measurement Issues

Health plan performance assessment methods are continually under development. Each year, HEDIS measures are refined and new measures are added to create a reliable and valid means of evaluation. Factors to consider when interpreting the results are highlighted throughout this report, when applicable. In addition to differences in quality, the following issues can cause variation in HEDIS results.

- HEDIS measures collected using the hybrid or survey methodology are calculated from samples of the plan population. Although plans' sampling methods conform to statistical methods, there is still a small chance that the sample does not represent the underlying population. The likelihood of this random error occurring is small, but the estimate obtained with a sample may produce a result that exceeds the error tolerance of 5% set by HEDIS specifications.
- Some measures in the *Effectiveness of Care* domain allow optional exclusions. This means that MCOs are allowed to exclude certain members from the denominator if they are identified as having had a certain procedure or comorbidity (e.g., women who have had bilateral mastectomies may be excluded from the *Breast Cancer Screening* measure). The MCO is not required to make these exclusions, but may do so to improve the accuracy of its rates.
- HEDIS results are not risk adjusted, which may account for variation in rates for some HEDIS measures, such as measures in the *Use of Services* domain and the *Frequency of Selected Procedures* measure. There may be differences in plan populations that cause rate variation, even when the quality of health care delivered is the same. For example, Plan A may have a sicker population than Plan B. Although both plans may provide the same quality of care, Plan A may have higher utilization rates for some services because its members need more medical care than the healthier members of Plan B do. Results are not due to differences in performance. Studies supported by AHRQ have shown differences in HEDIS rates due to education and economic differences in plan members. Better-educated members tend to demand, and receive, better services.

EFFECTIVENESS OF CARE

EFFECTIVENESS OF CARE

Overview

This section contains results for measures in the HEDIS 2006 *Effectiveness of Care* domain that MHCC required Maryland commercial HMOs to report in 2006. The measures listed below are designed to illustrate a plan's delivery of clinical services in accordance with established and widely accepted guidelines. *Effectiveness of Care* measures indicate what percentage of people who should have received a service actually received it. For all of the measures presented in this section, higher rates indicate better performance.

Measures in Domain

- Childhood Immunization Status
- Adolescent Immunization Status
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Chlamydia Screening in Women
- Controlling High Blood Pressure
- Beta-Blocker Treatment After a Heart Attack
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Cholesterol Management After Acute Cardiovascular Event
- Comprehensive Diabetes Care
- Use of Appropriate Medications for People with Asthma
- Flu Shots for Adults Ages 50–64
- Colorectal Cancer Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Medical Assistance With Smoking Cessation

Measures Eligible for Rotation in HEDIS 2006

- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Cervical Cancer Screening

Plans that rotated any of these measures are identified by a superscript "r" in the results tables.

CHILDHOOD IMMUNIZATION STATUS

Background

According to the Centers for Disease Control and Prevention (CDC), childhood immunizations prevent 10.5 million cases of illness and 35,000 deaths each year in the United States. In 2004, about 81% of American infants and toddlers were vaccinated before their third birthday. Maryland's rate was 82%, slightly higher than the national average (CDC, 2006).

Although the incidence of preventable childhood diseases has declined due to high rates of vaccination in school-age children, many children still do not receive sufficient immunization to meet recommended guidelines. Data gathered from the 2003 National Immunization Survey showed that approximately 29% of children in the United States were undervaccinated for one to six months, while 37% were undervaccinated for more than six months. Additionally, approximately 21% of children were undervaccinated for more than six months and for four or more vaccines (JAMA, 2005).

Several studies have investigated the reasons that many children remain undervaccinated and the characteristics of families from which these children come. Gaps in vaccination are associated with unmarried mothers, mothers with no college education, families with two or more children, being non-Hispanic Black, having multiple vaccination providers, and using public providers (JAMA, 2005). There are also misconceptions about vaccinations that influence parents' decisions. Parents who have never seen an outbreak of these diseases or who believe the diseases are no longer present in today's society may not be willing to obtain immunizations for their child. Others may feel that side effects or risk of illness outweigh the risk of disease. Together, these factors can lead to children not receiving the proper vaccines (CDC, 2004).

The body of evidence shows there is opportunity for vaccination programs to improve and ensure safety for everyone. Interventions should target populations that studies have found to have a higher likelihood of being undervaccinated. Some possible strategies include implementing reminder-recall systems, creating extended office hours for parents who are unable to take time off from work, expanding availability of pediatric care, and educating parents about the importance and safety of vaccinations (JAMA, 2005).

The following is a schedule of immunizations recommended as of December 2005 by the CDC, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians.

Table 5: Recommended Childhood Immunizations

Age	DTaP/ DT	IPV	MMR	Hep B	HiB	VZV	PCV
Birth–2 months				✓			
1–4 months				✓			
2 months	✓	✓			✓		✓
4 months	✓	✓			✓		✓
6 months	✓				✓		✓
6–18 months		✓		✓			
12–15 months			✓		✓		✓
12–18 months						✓	
15–18 months	✓						

Source: American Academy of Family Physicians, Recommended Childhood Immunization Schedule–United States, 2006;
http://www.aafp.org/online/en/home/clinical/immunizations/immunizationrecs/childimmunizations.html

Vaccine Abbreviations

DTaP/DT = Diphtheria, tetanus, and pertussis vaccine/diphtheria, tetanus
IPV = Inactivated polio vaccine (polio)
MMR = Measles, mumps, and rubella
Hep B = Hepatitis B
HiB = Haemophilus influenza type b
VZV = Varicella zoster virus (chicken pox)
PCV = Pneumococcal conjugate vaccine (pneumonia)

A recent vaccination survey of children ages 24–35 months reported that Maryland was one of the top-ranked states in vaccination coverage (Luman, Barker, McCauley, & Drews-Botsch, 2005). A comparison of Maryland with national rates of childhood immunization rates at 19 months shows the state exceeds national levels in six out of seven vaccines recommended in childhood. Two of these vaccines (HiB and PCV) show statistically significant higher vaccination completion rates than the national average.

Table 6: Estimated Percentage of Vaccination Coverage for the United States and Maryland for 7 Individual Vaccines at 19 Months

	DTaP/ DT	IPV	MMR	Hep B	HiB	VZV	PCV
Maryland	71.1	83.2	89.6	91.4	94.9	83.9	72.6
Nation	70.1	83.7	88.0	88.9	90.8	83.2	69.8

Estimates based on 95% confidence interval

Source: National Immunization Survey, http://www2a.cdc.gov/nip/coverage/nis/nis_iap.asp?fmt=v&rpt=tab08_19mo_iap&qtr=Q1/2004-Q4/2004

The Maryland Center for Immunization offers ImmuNet to Maryland immunization providers. ImmuNet is Maryland's immunization registry, a confidential and secure computer database designed to collect and maintain accurate, confidential, and current vaccination records. ImmuNet currently contains over 1,000,000 patient records. Used in 110 locations, it helps providers and health plans track when children need vaccination.. Some of its features include assisting in vaccine management, printing completed school immunization certificates, consolidating immunization records, and providing offices with the capability to print reminders. Immunet helps public health officials improve the overall status of immunization in Maryland.

Measure Definition

The *Childhood Immunization Status* measure shows the percentage of children who turned 2 years old during 2005, were continuously enrolled in their health plan for the 12 months immediately preceding their second birthday, and received the vaccines listed below. The measure produces rates for each combination of antigens and rates for the specific antigens comprising combination vaccine.

Combination 2	**Combination 3**
4 DTaP/DT	4 DTaP/DT
3 IPV	3 IPV
1 MMR	1 MMR
3 Hep B	3 Hep B
3 HiB	3 HiB
1 VZV	1 VZV
	4 PVC

Data Collection Methodology

This measure is collected using the hybrid methodology.

Summary of Changes to HEDIS 2006

- *Combination 1* was retired.
- *Combination 3* was created with the addition of PVC to the list of antigens in *Combination 2.*

Star Performer

Combination 2 is included in the *2006/2007 Consumer Guide;* therefore, it is eligible for Star Performer designation.

Notes

Combination 2 is largely compliant with broad guidelines set by the CDC; however, the CDC also recommends four PCV for all children ages 2–23 months, which warranted its inclusion in HEDIS 2006.

Beginning in 2003, HEDIS guidelines do not count as "compliant" any DTaP/DT, IPV, or HiB vaccination given to a child younger than six weeks. (DTP vaccinations are no longer manufactured; however, notations of DTP in medical records count toward the numerator.) Administration of the oral polio vaccine does not meet the criteria for this measure because use of this antigen was discontinued in 1999.

Several factors complicate calculating this measure and can lead to underreporting. When interpreting results, readers should consider the following.

- Children who receive some—or even most—but not all of the immunizations specified for the combination are excluded from the numerator for *Combination 2* and *Combination 3*. Vaccine-specific or single antigen rates are almost always higher than the rates for combinations.
- Plans may have difficulty documenting immunizations that children received outside of their provider network (e.g., at schools, local health departments).
- Disease history may not be documented. Unless a child's medical record shows evidence of having had the disease, underreporting will occur without the necessary documentation of the specific medical event.
- Poor quality of coding for ambulatory data is commonly found in capitated managed care environments and can complicate accurate measurement. This happens when providers do not include antigen-specific codes for immunizations on encounter forms submitted to plans.
- Many children receive recommended immunizations shortly *after* their second birthday. Although the intent of the measure is satisfied, these children must be excluded (as indicated in the *HEDIS 2006, Volume 2: Technical Specifications*, which guides the calculation of rates for HEDIS measures to ensure comparability of results across plans).

Results

Combination 2 (see Table 7)

- From 2004–2006, the Maryland HMO/POS average increased 6 percentage points to 81%.
- Two plans showed significant improvements in their performance between 2004 and 2006.
- In 2006, rates ranged from 73%–86%, with three plans receiving above-average scores, one plan receiving an average score, and three plans receiving below-average scores.
- One plan received Star Performer designation for this measure.

Antigen-Specific Vaccination Rates (see Table 8)

- This table shows the rates for antigen-specific vaccinations.
- The Maryland HMO/POS average for the *Combination 3* measure is 54%. This is the first year plans have collected this combination of immunizations for this population.

Table 7

Childhood Immunization Status Combination 2, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**75%**	**77%**	**81%**	**6%**			
Aetna	66%	71%	84%	⇑	★	★	★★★
BlueChoice	69%	75%	83%	⇑	★	★★	★★
CIGNA	81%	81%	85%	⇔	★★★	★★	★★★
Coventry	81%	81%	77%	⇔	★★★	★★	★
Kaiser Permanente	86%	86%	86%	⇔	★★★	★★★	★★★★
M.D. IPA	74%	75%	73%	⇔	★★	★★	★
OCI	72%	72%	76%	⇔	★★	★	★

Legend

Change 2004–2006

- ⇑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 8

Childhood Immunization Status, 2006 Results														
Percentage of Children Immunized														
	Combination 2		DTaP		IPV		MMR		HiB		Hep B		VZV	
Maryland HMO/POS Average	81%		87%		92%		94%		93%		90%		93%	
Aetna	84%	★★★	90%	★★	92%	★★	95%	★★	95%	★★	93%	★★★	94%	★★
BlueChoice	83%	★★	88%	★★	93%	★★	95%	★★	94%	★★	93%	★★★	94%	★★
CIGNA	85%	★★★	89%	★★	93%	★★	93%	★★	96%	★★★	93%	★★★	93%	★★
Coventry	77%	★	83%	★	89%	★	93%	★★	90%	★	87%	★★	91%	★★
Kaiser Permanente	86%	★★★★	91%	★★★	95%	★★★	95%	★★	93%	★★	94%	★★★	95%	★★
M.D. IPA	73%	★	86%	★★	91%	★★	93%	★★	93%	★★	84%	★	91%	★★
OCI	76%	★	85%	★★	90%	★★	94%	★★	91%	★★	84%	★	92%	★★

Legend

Relative Rates

★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).

★★★ = Plan performed significantly better than the Maryland HMO/POS average.

★★ = Plan performed equivalent to the Maryland HMO/POS average.

★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

ADOLESCENT IMMUNIZATION STATUS

Background

Immunizations are just as important in protecting the health of adolescents as they are for younger children. Although immunization interventions focus primarily on infants and children, some diseases pose a greater risk during the adolescent years. For example, the CDC reported that in the United States nearly 40% of whooping cough (pertussis) cases have been in adolescents between the ages of 10 and 18 years. During the 1990s, the incidence of pertussis in adolescents and children more than doubled, mostly because the vaccines that were used in the past had lost their effectiveness. The pertussis vaccine is usually administered to infants in their first year of life, through the DTaP vaccine, but immunity to the pertussis vaccine has been shown to weaken after 6–10 years, thus increasing the risk of exposure to the disease during adolescence. In 2004, the highest concentration of pertussis cases was seen among adolescents between the ages of 10 and 18 years, making up about 6,500 of the estimated 19,000 total reported cases.

In response to the rise in the number of whooping cough cases in infants who have not been immunized, as well as in adolescents and adults, the CDC recommends that adolescents ages 11–12 years get the whooping cough booster vaccine. In 2005, the *New England Journal of Medicine* reported results from a study that showed a new vaccine to be highly effective for preventing pertussis in adults and adolescents. The study concluded that a single dose of the acellular pertussis vaccine is 92% effective in protecting adolescents and adults against pertussis. The added benefit of this new vaccine, the study noted, is that it prevents transmission of whooping cough to infants who are often very susceptible to severe illness, or even death, if infected by the pertussis bacterium.

Other vaccine-preventable diseases that affect children during their adolescent years include bacterial meningitis and hepatitis B. Since 1991, the Advisory Committee on Immunization Practices (ACIP)[1] has made the Hep B vaccine a routine part of childhood and adolescent vaccinations, leading to a decline in the number of new infections from an average of 260,000 in the 1980s to about 60,000 in 2004, with the greatest decline among children and adolescents (CDC, 2006).

[1] The ACIP comprises 15 experts in fields associated with immunization who have been selected by the Secretary of the U.S. Department of Health and Human Services to provide advice and guidance to the Secretary, the Assistant Secretary for Health, and the CDC on the most effective means to prevent vaccine-preventable diseases.

Table 9: Recommended Adolescent Immunizations, 2006

Age	DTaP/ DT	IPV	MMR	Hep B	VZV	Td	Hep A
2 years +							✓
4–6 years	✓	✓	✓				
11–12 years				✓	✓		
11–16 years						✓	

* *Source: DHMH, Center for Immunization Recommended Childhood Immunization Schedule—2006 includes two doses of hepatitis A vaccine for Baltimore City residents.*

Vaccine Abbreviations

DTaP/DT = Diphtheria, tetanus, and pertussis/diphtheria, tetanus
Hep A = Hepatitis A
Hep B = Hepatitis B
IPV = Inactivated polio vaccine (for polio)
Td = Tetanus and diphtheria
MMR = Measles, mumps, and rubella
VZV = Varicella zoster virus (for chicken pox)

Measure Definition

The *Adolescent Immunization Status* measure shows the percentage of adolescents who turned 13 years of age during 2005, were continuously enrolled for 12 months immediately preceding their 13th birthday, and received the following immunizations.

Combination 2
1 MMR
3 Hep B
1 VZV

The measure produces a rate for the combination of antigens, as well as rates for specific antigens in *Combination 2*.

Data Collection Methodology

This measure is collected using the hybrid methodology.

Summary of Changes to HEDIS 2006

Combination 1 was retired.

Star Performer

Combination 2 is included in the *2006/2007 Consumer Guide*; therefore, it is eligible for Star Performer designation.

Notes

Several factors complicate calculating this measure and can lead to underreporting. When interpreting results, readers should consider the following.

- Adolescents who receive some, but not all, of the vaccines specified for the combination are excluded from the rate. Vaccine- or antigen-specific rates are typically higher than combination rates.
- Plans may have difficulty documenting immunizations that adolescents received outside of the provider network (e.g., at schools, local health departments).
- Disease history may not be documented. Unless a child's medical record shows evidence of having had the disease, underreporting will occur without the necessary documentation of a key event.
- Poor quality in coding of ambulatory data is commonly found in capitated managed care environments and can complicate accurate measurement. Providers often do not include antigen-specific codes for immunizations on encounter forms submitted to plans.

Results

Combination 2 (see Table 10)

- From 2004–2006, the Maryland HMO/POS average increased 12 percentage points to 60%.
- Five of the seven plans showed statistically significant improvements in their rates, while two plans had no significant change.
- In 2006, rates ranged from 47%–81%, with one plan receiving an above-average score, three plans receiving average scores, and three plans receiving below-average scores.
- One plan received Star Performer designation for this measure.

Antigen-Specific Vaccination Rates (see Table 11)

- This table shows the rates for antigen-specific vaccinations.
- The Maryland HMO/POS average rates for VZV and Hep B vaccination (67% and 74%, respectively) were lower than that for MMR (79%). Also, these rates were lower when compared to the *Childhood Immunization Status* rates for these vaccinations (93%, 90%, and 94%, respectively).

Table 10

Adolescent Immunization Status Combination 2, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**48%**	**53%**	**60%**	**12%**			
Aetna	37%	55%	62%	↑	★	★★	★★
BlueChoice	43%	50%	61%	↑	★	★★	★★
CIGNA	50%	54%	55%	⇔	★★	★★	★
Coventry	56%	56%	58%	⇔	★★★	★★	★★
Kaiser Permanente	71%	71%	81%	↑	★★★	★★★	★★★★
M.D. IPA	43%	42%	54%	↑	★	★	★
OCI	36%	44%	47%	↑	★	★	★

Table 11

Adolescent Immunization Status, 2006 Results								
Percentage of Adolescents Immunized								
	Combination 2		MMR		Hep B		VZV	
Maryland HMO/POS Average	60%		79%		74%		67%	
Aetna	62%	★★	80%	★★	74%	★★	69%	★★
BlueChoice	61%	★★	81%	★★	77%	★★	70%	★★
CIGNA	55%	★	78%	★★	75%	★★	60%	★
Coventry	58%	★★	86%	★★★	81%	★★★	63%	★★
Kaiser Permanente	81%	★★★★	87%	★★★	86%	★★★	84%	★★★
M.D. IPA	54%	★	73%	★	67%	★	62%	★
OCI	47%	★	70%	★	57%	★	61%	★

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Background

An estimated 10% of all children in the United States who see a medical care provider within a given year will be evaluated for pharyngitis (Simon, 2006). Pharyngitis, an inflammation in the throat frequently resulting in complaints of sore throat, is caused most often by viruses; however, approximately 15%–30% of cases in children occur from Group A streptococcus bacterial infection (American Academy of Family Physicians, 2003). Streptococcal pharyngitis, or strep throat, requires antibiotic treatment to decrease the period of time a person experiences symptoms and to decrease the risk of rheumatic fever.

Much of the misuse of antibiotics in treating pharyngitis is due to physician carelessness in using diagnostic testing and in prescribing medications. A strep test is the diagnostic test used to identify Strep A infections, so it would be expected that any patient who is prescribed antibiotics would have received a strep test to confirm presence of a bacterial infection. Despite the recommended guideline for testing, many physicians treat pharyngitis before they have test results. It has been shown that annually, 49% of children who are prescribed antibiotics (and who, presumably, have a Strep A infection) are not prescribed this test (JAMA, 2005).

A 2004 study conducted with physicians from the American Academy of Family Physicians and the American Academy of Pediatrics showed that 42% of surveyed physicians would start a patient on antibiotics before ruling out a Group A streptococcus infection by obtaining test results, and continue them even after test results ruled out the bacterial infection. Moreover, when presented with a clinical scenario of children who presented with acute pharyngitis, 81% of the physicians chose a treatment strategy that is inappropriate for a child whose test result was consistent with infection from viral pharyngitis. These physicians also chose wrong testing strategies, which included prescribing diagnostic tests for children who clearly had viral pharyngitis and prescribing follow-up tests for children without symptoms (Pediatrics, 2006).

These studies suggest that strategies need to be developed to help physicians better manage testing and treatment for pharyngitis. The 2004 study concluded with recommendations to use standardized health care quality measures that would help physicians better adhere to appropriate use of diagnostic testing and treatment guidelines, as well as educational programs for residents and practicing physicians.

Measure Definition

The *Appropriate Testing for Children with Pharyngitis* measure shows the percentage of children ages 2–18 years who were diagnosed with bacterial pharyngitis and prescribed an antibiotic, and who received a Group A streptococcus test for the episode.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes to HEDIS 2006

No significant changes.

Star Performer

This measure is not reported in the *2006/2007 Consumer Guide;* therefore, it is not eligible for Star Performer designation.

Results *(see Table 12)*

- From 2004–2006, the Maryland HMO/POS average decreased by 1 percentage point to 74%.
- Three plans showed a statistically significant increase in their rate, one plan's rate did not change, and three plans' rates decreased significantly.
- In 2006, rates ranged from 65%–94%, with three plans receiving above-average scores and four plans receiving below-average scores.

Table 12

Appropriate Testing for Children with Pharyngitis, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**75%**	**78%**	**74%**	**-1%**			
Aetna	68%	74%	71%	↑	★	★	★
BlueChoice	72%	82%	76%	↑	★	★★★	★★★
CIGNA	77%	78%	76%	⇔	★★★	★★	★★★
Coventry	60%	72%	65%	↑	★	★	★
Kaiser Permanente	96%	89%	94%	↓	★★★	★★★	★★★
M.D. IPA	77%	75%	68%	↓	★★	★	★
OCI	76%	76%	67%	↓	★★	★	★

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

Background

According to the American Academy for Family Physicians, cough, pharyngitis, and the common cold (upper respiratory infections [URI]) are three of the five conditions that account for most (75%) of the outpatient prescribing of antibiotics in the United States. Use is seen most often in children. Many studies have shown that antibiotics do nothing to hasten the course of recovery from the common cold, but nevertheless, physicians continue to prescribe them. From 1996–2001, 4% of American children ages 1–14 years were prescribed antibiotics to treat a URI (Miller & Hudson, 2006). The CDC estimates that if medical providers consistently practiced the Principles of Antimicrobial Therapy (listed below), there would be 50 million fewer prescriptions for antibiotics in the United States each year.

1. Antimicrobial agents should not be given for the common cold.
2. Mucopurulent rhinitis (thick, opaque or discolored nasal discharge) frequently accompanies the common cold. It is not an indication for antimicrobial treatment unless it persists for longer than 10–14 days.

One reason found among physicians for prescribing antibiotics for common colds is that they feel that they will help prevent any bacterial complications that may arise from the cold; however, this is harmful because these patients can become infected by resistant bacteria. Moreover, the widespread transmission of drug-resistant pathogens poses a public health threat. Studies have shown that consumers often drive inappropriate prescribing of antibiotics. Many consumers are misguided about the proper use of antibiotics, are unaware of the harm of misuse, and expect to be prescribed antibiotics when they go into the doctor's office with a cold. One survey of consumer attitudes about antibiotic use showed that 48% of people expected to be prescribed antibiotics when they saw a doctor for a common cold, and 58% were not aware of the possible dangers of antibiotic misuse (Vanden et al., 2003). It is this expectation by parents that coerces physicians into inappropriately prescribing antibiotics to treat URIs in children.

Measure Definition

The *Appropriate Treatment for Children with Upper Respiratory Infection* measure shows the percentage of children ages 3 months to 18 years who were diagnosed with URI and were *not* dispensed an antibiotic on or three days after the diagnosis.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes to HEDIS 2006

There were no significant changes.

Star Performer

This measure is not reported in the *2006/2007 Consumer Guide;* therefore, it is not eligible for Star Performer designation.

Notes

- This measure assesses whether antibiotics were inappropriately prescribed for children with URI.
- This measure is reported as an inverted rate [1 – (numerator/ denominator)]; therefore, a higher score indicates appropriate treatment of children with URI (the number of children who were *not* prescribed an antibiotic).

Results *(see Table 13)*

- The Maryland HMO/POS average stayed at the same rate (89%) from 2005 to 2006 and increased by 2 percentage points from 2004.
- In 2006, rates ranged from 77%–95%, with four plans receiving above-average scores and three plans receiving below-average scores.
- Two plans experienced a significant increase in their rates, while the remaining five plans had no significant change.

Table 13

Appropriate Treatment for Children with Upper Respiratory Infection, Trending							
	Comparison of Absolute Rates				*Comparision of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**87%**	**89%**	**89%**	**2%**			
Aetna	83%	82%	84%	⇔	★	★	★
BlueChoice	90%	90%	94%	⇑	★★★	★★★	★★★
CIGNA	84%	87%	85%	⇔	★	★	★
Coventry	80%	90%	77%	⇔	★	★★	★
Kaiser Permanente	84%	85%	91%	⇑	★	★	★★★
M.D. IPA	95%	95%	95%	⇔	★★★	★★★	★★★
OCI	95%	94%	94%	⇔	★★★	★★★	★★★

Legend

Change 2004–2006

⇑ Plan rate increased significantly from 2004 to 2006.
⇔ Plan rate *did not* change significantly from 2004 to 2006.
⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

CHLAMYDIA SCREENING IN WOMEN

Background

Chlamydia is the most commonly reported sexually transmitted disease (STD) in the United States, with approximately 3 million new cases each year (CDC, 2006). Chlamydia screening is extremely important because most infected women (70%) have no discernible symptoms. When it is undetected and untreated in women, it can lead to pelvic inflammatory disease (PID), infertility, ectopic pregnancy, and chronic pelvic pain (Pozniak, 2005). A woman with chlamydia is also up to five times more likely to acquire HIV if exposed (CDC, 2006). Screening programs have decreased chlamydia and PID in young women by 60%, lowering hospitalization and complication rates (Shafer et al., 2002).

There are several different types of screening tests, all varying on the level of skill required for collection, testing, and transportation of specimen; type of specimen used; technical expertise, sensitivity, and specificity, among other factors. Controversy exists as to whether to rely mostly on the newer, higher-technology amplification tests, which have a higher specificity and sensitivity, or whether to use the older, less-expensive tests. The American College of Medicine recommends that the decision about which test to use rest on availability of funding and the prevalence of chlamydia in the particular population (2003).

Another controversy is whether universal screening is more cost effective than selective screening, or vice versa. Some studies have suggested that screening based on age group proves to be the most cost effective, whereas others have argued that screening should be made universal in populations with a high prevalence of chlamydia. Different groups such as The American College of Preventive Medicine (ACPM), the CDC, the American Medical Association (AMA), and the American Academy of Pediatrics all have recommendations about screening, giving specific guidelines with regard to age, high-risk groups, frequency of screening, and other criteria.

Regardless of these controversies, it is widely understood that screening using any, or a combination, of the available strategies is economically beneficial to society compared with no screening at all (ACPM, 2003).

Chlamydia is the most frequently reported STD in Maryland. In 2004, the Maryland rate was 362.2 per 100,000 population, compared to the United States average of 319.6 cases per 100,000 population (CDC, 2004). In 2005, the Community Health Administration of the Maryland Department of Health and Mental Hygiene reported 18,308 cases, about an 18% decrease from 2004.

Measure Definition

The *Chlamydia Screening in Women* measure shows the percentage of sexually active women ages 16–25 years who were continuously enrolled during 2005 and who had at least one test for chlamydia during the measurement year.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes to HEDIS 2006

No significant changes.

Star Performer

The *Chlamydia Screening in Women* measure (ages 16–25 years) is included in the *2006/2007 Consumer Guide;* therefore, it is eligible for Star Performer designation.

Notes

There are two methods to identify sexually active women for inclusion in the measure: through pharmacy data or through medical claims/encounter data.

Several factors complicate calculating this measure and can influence results. When interpreting results, readers should consider the following.

- Pharmacy data and claims/encounter data cannot be used to identify all women who were sexually active, but can be used to identify only those who received care related to sexual activity, such as prescriptions for contraceptives and pregnancy-related care. The actual number of women at risk is much larger than the number screened. The percentage of women being screened by some plans is only a small fraction of those who meet the criteria for screening. Women meeting the criteria for screening, in turn, make up only a small percentage of women at risk.
- Due to privacy concerns, providers may underreport the number of chlamydia tests performed.

Results *(see Tables 14-16)*

- Plan rates for the 16–25 age group ranged from 35%–76%; six plans received below-average scores, five plans had a significant increase in their rates, while two plans saw no significant change.
- For the 16–25 age group, one plan received the Star Performer designation, although its rate did not change between 2004 and 2006.

Table 14

Chlamydia Screening Ages 16-20, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**38%**	**43%**	**43%**	**5%**			
Aetna	26%	39%	42%	↑	★	★	★
BlueChoice	28%	39%	35%	↑	★	★	★
CIGNA	33%	34%	35%	⇔	★	★	★
Coventry	41%	38%	40%	⇔	★★	★	★
Kaiser Permanente	77%	77%	72%	↓	★★★	★★★	★★★
M.D. IPA	35%	37%	41%	↑	★	★	★
OCI	30%	34%	37%	↑	★	★	★

Table 15

Chlamydia Screening Ages 21-25, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**37%**	**41%**	**44%**	**7%**			
Aetna	25%	36%	40%	↑	★	★	★
BlueChoice	33%	35%	36%	↑	★	★	★
CIGNA	33%	37%	35%	⇔	★	★	★
Coventry	35%	38%	39%	↑	★	★	★
Kaiser Permanente	75%	79%	79%	↑	★★★	★★★	★★★
M.D. IPA	31%	34%	40%	↑	★	★	★
OCI	29%	31%	38%	↑	★	★	★

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 16

Chlamydia Screening Combined Ages 16-25, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	2004-2006	2004	2005	2006
Maryland HMO/POS Average	**38%**	**42%**	**43%**	**5%**			
Aetna	25%	38%	41%	⇑	★	★	★
BlueChoice	31%	37%	35%	⇑	★	★	★
CIGNA	33%	36%	35%	⇑	★	★	★
Coventry	38%	38%	39%	⇔	★★	★	★
Kaiser Permanente	76%	78%	76%	⇔	★★★	★★★	★★★★
M.D. IPA	33%	36%	41%	⇑	★	★	★
OCI	30%	32%	37%	⇑	★	★	★

Legend

Change 2004–2006

⇑ Plan rate increased significantly from 2004 to 2006.
⇔ Plan rate *did not* change significantly from 2004 to 2006.
⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

CONTROLLING HIGH BLOOD PRESSURE

Background

High blood pressure (hypertension) is a common medical condition found in 25% of the entire United States population. The risk of developing hypertension increases greatly with age and is a large risk factor for cardiovascular disease (Wang & Vasan, 2005). Close to 50% of Americans over the age of 45 years have high blood pressure (Jones & Hall, 2002). In clinical trials, controlling hypertension has been associated with a 35%–40% reduction in strokes, a 20%–25% reduction in myocardial infarction (MI), and a more than 50% reduction in heart failure. Despite available effective treatment options, studies show that 65% of hypertension is uncontrolled, either undertreated or not identified (Wang et al., 2005).

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-7) indicated four major demographic factors that influence the prevalence of hypertension (Chobanian et al., 2003).

- **Age:** Prevalence and risk of hypertension is higher in adults ages 40–89 years.
- **Gender:** Hypertension is more common among men in early adulthood. After the age of 50, the rate of new hypertension cases is higher for women. After the age of 60, there is no gender difference in hypertension prevalence.
- **Race:** Blacks are more likely than Whites to have hypertension.
- **Socioeconomic status:** People with lower incomes and educational levels are more likely to have hypertension than those with higher incomes and education levels.

Measure Definition

The *Controlling High Blood Pressure* measure shows the percentage of members ages 46–85 years who were continuously enrolled in 2005 and who had a diagnosis of hypertension. Adequate control was defined as a blood pressure reading of 140/90 mmHg or lower during the past year. Both systolic and diastolic pressure must be at or under this threshold for blood pressure to be considered controlled.

> *In HEDIS 2007, the specifications for this measure will change to include a decrease in the lower age limit, from age 46 to age 18, and a change in the blood pressure measurement to <140/90 mmHg.*

Data Collection Methodology

This measure is collected using the hybrid methodology. This measure is eligible for rotation in HEDIS 2006.

Summary of Changes to HEDIS 2006

There were no significant changes.

Star Performer

This measure was included in the *2006/2007 Consumer Guide*; therefore, it is eligible for Star Performer designation.

Results *(see Table 17)*

- From 2004–2006, the Maryland HMO/POS average increased by 8 percentage points to 73%. Three plans had percentage point increases greater than this.
- Four plans had statistically significant increases in their rates and three plans did not have statistically significant changes in their rates.
- In 2006, rates ranged from 65%–81%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.

Table 17

Controlling High Blood Pressure, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**65%**	**66%**	**73%**	**8%**			
Aetna	61%	67%	71%	↑	★	★★	★★
BlueChoice[r]	66%	70%	70%	⇔	★★	★★	★★
CIGNA	76%	79%	81%	⇔	★★★	★★★	★★★★
Coventry[r]	57%	65%	65%	↑	★	★★	★
Kaiser Permanente	79%	73%	77%	⇔	★★★	★★★	★★
M.D. IPA	60%	55%	76%	↑	★	★	★★
OCI[r]	59%	53%	71%	↑	★	★	★★

Legend

Change 2004–2006

↑ Plan rate increased significantly from 2004 to 2006.
⇔ Plan rate *did not* change significantly from 2004 to 2006.
↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2006 and this plan elected to resubmit 2005 data in 2006.

BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

Background

Over 1 million heart attacks occur in the United States each year, resulting in 515,000 deaths. One-half of those who die do so within one hour of symptom onset (National Heart Lung and Blood Institute, 2003). Approximately 450,000 Americans who have had a heart attack will experience a second one because of an increased risk. Beta-blockers reduce the risk of death by 25%–40% and reduce sudden cardiac death by up to 50% in patients who had recent heart attacks. They also reduce the risk of recurrence of subsequent acute myocardial infarctions (AMI) and other cardiac problems. The earlier treatment is started, the higher the reduction in risk (Journal of the American Heart Association, 2002).

Because of the huge benefit that beta-blockers provide to AMI patients, it is critical that every patient who qualifies for beta-blocker treatment receives it. The American College of Cardiology recommends that beta-blockers be administered promptly to patients with no contraindication and that patients be discharged with a prescription for it. Contrary to this recommendation, studies have shown that patients often leave the hospital without being prescribed the medication, and even when discharged with beta-blockers, they do not always adhere to the treatment. One study found that patients who are not being treated with beta-blockers during hospitalization are even more likely to not follow this treatment regimen after discharge. Also, post-discharge adherence to the therapy decreases even for those who do receive it while in the hospital (Journal of the American College of Cardiology, 2002).

A 2005 study supported by the Agency for Healthcare Research and Quality (AHRQ) investigated the link between hospitals and the likelihood for patients to receive appropriate beta-blocker treatment after a heart attack. The study found that hospitals having greater support for quality improvement from nurses, physicians, and administrators; those having physician advocates for quality improvement; and those having adequate resources to promote quality improvement are more likely to prescribe beta-blockers to their patients. The study found that the percentage of patients prescribed beta blockers varied widely among hospitals. The range spanned from 19% to 89%, while, on average, hospitals in the study prescribed beta blockers to 60% of their patients. Also, the top-performing 20% of hospitals were almost twice as likely to have organizational support for quality improvement efforts and almost 10 times as likely to have physicians advocate for quality improvement, when compared to the 20% of hospitals considered low performing (AHRQ, 2005).

Physicians need to better adhere to treatment guidelines regarding beta-blockers and to educate their patients about the importance of continuing beta-blocker treatment upon discharge from the hospital. Hospitals also need to play a quality assurance and support role in ensuring that their physicians meet recommended guidelines for treating AMI and that patients are provided with quality care.

Measure Definition

The *Beta-Blocker Treatment after a Heart Attack* measure shows the percentage of members age 35 years and older who were hospitalized and discharged alive with a diagnosis of AMI and dispensed a beta-blocker prescription upon discharge.

Data Collection Methodology

This measure is collected using the hybrid methodology.

Summary of Changes to HEDIS 2006

There were no significant changes.

Star Performer

This measure is not reported in the *2006/2007 Consumer Guide;* therefore, it is not eligible for Star Performer designation.

Notes

When interpreting these rates, readers should understand that plans may exclude any member identified as having a contraindication or previous adverse reaction to beta-blocker therapy.

Results *(see Table 18)*

- From 2004–2006, the Maryland HMO/POS average increased 1 percentage point to 97%.
- In 2006, rates ranged from 90%–100%, with two plans receiving above-average scores, four plans receiving average scores, and one plan receiving a below-average score.
- Only one of the seven plans showed a statistically significant increase in its rate, while the other plans did not have statistically significant changes in their rates.

Table 18

Beta-Blocker Treatment After Heart Attack, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**96%**	**96%**	**97%**	**1%**			
Aetna	96%	96%	98%	⇔	★★	★★	★★
BlueChoice	95%	97%	98%	🡅	★★	★★	★★
CIGNA	97%	97%	99%	⇔	★★	★★	★★★
Coventry	100%	100%	99%	⇔	★★★	★★★	★★
Kaiser Permanente	100%	100%	100%	⇔	★★★	★★★	★★★
M.D. IPA	94%	92%	94%	⇔	★★	★	★★
OCI	92%	88%	90%	⇔	★	★	★

Legend

Change 2004–2006

- 🡅 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡇 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

Background

According to the American Heart Association (AHA), an estimated 7.2 million Americans age 20 years and older have a history of myocardial infarction (MI) (AHA, 2006). Long-term use of beta-blockers has been shown to reduce morbidity and mortality in patients surviving a heart attack, including high-risk patients such as the elderly, patients with diabetes, and patients with heart failure (ASHP, 2002). Despite high rates of beta-blocker prescription in the acute phase, adherence to the therapy declines significantly within the first year after an MI (Phillips et al., 2000). The AHA and the American College of Cardiology strongly recommend treatment using beta-blockers following a heart attack to reduce mortality during acute and long-term management of MI (Ryan et al., 1996).

Measure Definition

The *Persistence of Beta-Blocker Treatment After a Heart* Attack measure shows the percentage of members ages 35 years and older who were hospitalized and discharged alive with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Data Collection Method

This measure is collected using the administrative methodology.

Summary of Changes to HEDIS 2006

There were no significant changes.

Star Performer

This measure is reported in the *2006/2007 Consumer Guide*; however, it is not eligible for Star Performer designation because it was first reported in 2005 and three years of data are not available.

Notes

When interpreting these rates, readers should understand that plans may exclude any member identified as having a contraindication or previous adverse reaction to beta-blocker therapy.

Results (*see Table 19)*

- The Maryland HMO/POS average increased 2 percentage points to 68% from 2005 to 2006.
- Rates ranged from 56%–80%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.

Table 19

Persistence of Beta-Blocker Treatment After Heart Attack				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2005	2006	2005	2006
Maryland HMO/POS Average	**66%**	**68%**		
Aetna	66%	64%	★★	★★
BlueChoice	59%	56%	★	★
CIGNA	64%	68%	★★	★★
Coventry	44%	75%	★	★★
Kaiser Permanente	75%	80%	★★★	★★★
M.D. IPA	80%	68%	★★★	★★
OCI	74%	68%	★★★	★★

Legend

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

CHOLESTEROL MANAGEMENT AFTER ACUTE CARDIOVASCULAR EVENT

Measure Definition

The *Cholesterol Management After Acute Cardiovascular Event* measure shows the percentage of members ages 18–75 years who were hospitalized and discharged alive in 2004 after an AMI, coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA). For these members, the following three rates are calculated.

- The percentage who received a cholesterol (LDL-C) screening on or between 60 and 365 days after discharge (screening).
- The percentage who had a cholesterol (LDL-C) level of <100 mg/dL on or between 60 and 365 days after discharge (control).
- The percentage who had a cholesterol (LDL-C) level of <130 mg/dL on or between 60 and 365 days after discharge (control).

Data Collection Methodology

This measure is collected using either the administrative or the hybrid methodology.

Summary of Change to HEDIS 2006

- Revised the eligible population and denominator to include members with ischemic vascular disease (IVD).
- Revised the time frame for event/diagnosis criteria.
- Revised the time frame for numerator events.

Data for this measure are not reported for 2006 due to addition of IVD and reports of high false-positive. Data are not trendable.

COMPREHENSIVE DIABETES CARE

Background

Diabetes is the sixth leading cause of death in the United States (National Institute of Diabetes and Digestive and Kidney Diseases, 2005). Over 14 million Americans have been diagnosed with diabetes and an additional 6 million Americans suffer from undiagnosed diabetes (American Heart Association, 2006). About 90%–95% of those diagnosed with diabetes have type 2 diabetes, which is associated with risk factors such as old age and obesity. This type can be controlled by diet or medication. While diabetes can be controlled and managed, no cure exists.

Many health complications can arise from diabetes. About 60%–70% of people with diabetes have mild to severe forms of nervous system damage. Long-term effects include impaired sensation in the feet and hands, carpal tunnel syndrome, and other nerve problems (National Institute of Neurological Disorders and Stroke, 2006). People with diabetes are more susceptible to acute illness and have worse health outcomes. For example, diabetics are more likely to die with pneumonia or influenza than people who do not have diabetes (CDC, 2005c)

Indicators of good diabetes care include the following.

Blood glucose monitoring and control: A hemoglobin A1C (HbA1c) test is a commonly accepted method of measuring blood glucose and determining whether a patient's diabetes is under control. It is estimated that for every one-point decrease in a patient's HbA1c level, the risk of developing diabetic complications involving the eyes, kidneys, and nervous system is reduced by up to 40% (National Institute of Diabetes and Digestive and Kidney Diseases, 2005).

Cholesterol monitoring and control: Lipid profiles should be performed regularly for patients with diabetes. When a diabetic patient's LDL-C cholesterol level is controlled, cardiovascular complications are reduced up to 20%–50% (American Diabetes Association, 2004).

Annual eye exams: Patients with diabetes should have their eyes examined regularly. An estimated 12,000–24,000 people lose their sight each year due to diabetes-related eye conditions (National Institute of Diabetes and Digestive and Kidney Diseases, 2005).

Kidney disease monitoring: Diabetes is a common cause of kidney failure, accounting for 45% of new cases a year (National Institute of Diabetes and Digestive and Kidney Diseases, 2006).

Measure Definition

The *Comprehensive Diabetes Care* measure shows the percentage of members with diabetes (types 1 and 2), ages 18–75, who were continuously enrolled during 2005 and had each of the following.

- Blood glucose (HbA1c) tested; blood glucose (HbA1c) controlled (≤9.0%)
- Cholesterol (LDL-C) tested; cholesterol (LDL-C) controlled (<130 mg/dL ***or*** <100 mg/dL)

- Eye exam (retinal)
- Kidney disease (nephropathy) monitored

Maryland health plans also report a *Comprehensive Diabetes Care* combination rate, which is the percentage of diabetic members who satisfy the numerator requirements for six of the seven *Comprehensive Diabetes Care* measures described above. The numerator for members whose LDL-C level is less than 100 mg/dL is not considered in the calculation of the combination rate.

Data Collection Methodology

This measure is collected using the administrative or hybrid methodology. For this measure only, a plan may elect to report only the administrative rate collected on the sample and opt not to perform medical record review. This measure is eligible for rotation in HEDIS 2006 (both screening and control rates must be rotated together).

Summary of Changes to HEDIS 2006

- The eye-exam low-risk criteria were revised.
- Plans were given a choice of using the administrative or the hybrid methodology.

Star Performer

The *Comprehensive Diabetes Care Eye Exam* and *Nephropathy Monitoring* measures are in the *2006/2007 Consumer Guide*; therefore, they are eligible for Star Performer designation.

Notes

Methods used to identify members with diabetes can influence final rates. NCQA requires plans to identify people with diabetes using pharmacy and encounter data. Encounters are "claims" sent to the plan when a member sees a provider. Pharmacy data alone tends to exclude people with type 2 diabetes, since medication is not always necessary. Relying on encounter data alone tends to find more false-positives or members who are incorrectly identified as diabetic. Use of both methods may improve the accuracy of the population used to calculate the rate for each plan.

Results

Blood Glucose Monitoring and Control (see Tables 21-22)

- The *Blood Glucose (HbA1c) Control* measure reveals that an average of 71% of plan members had HbA1c levels of 9.0% or less. Rates for this measure did not change significantly for any plans.
- On average, rates of screening blood glucose (85%) are higher than rates of blood glucose control (71%).
- One plan significantly increased its *Blood Glucose Testing*, while the other plans saw no significant change in their testing.

Cholesterol Monitoring and Control (see Tables 23-25)

- The percentage of members whose cholesterol levels were controlled, as reflected by the two measures of cholesterol control, increased 11 percentage points and 8 percentage points, respectively.
- For the control measure, all but two plans experienced statistically significant increases in their rate.
- The average rate for cholesterol control (LDL-C) at the level <100 mg/dL was much lower (49%) compared to that of LDL-C level <130 mg/dL (72%).

Annual Eye Exam (see Table 26)

- The Eye Exam rate had an average score of 57%, with rates ranging from 53% to 67%.
- One plan with a significant decrease in its rate received a Star Performer designation.

Kidney Disease Monitoring (see Table 27)

- The average rate for the *Monitoring for Diabetic Nephropathy* measure was 56%.
- Four plans had statistically significant increases in their rates, one had a significant decrease, and two had no significant changes in their rates.
- One plan received Star Performer designation for this measure.

Across Maryland Plans (see Tables 28 and 29)

- From 2004 to 2006, the largest average rate increases were for LDL-C level <100 mg/dL at 11%, LDL-C level <130 mg/dL at 8%, and Kidney Disease (nephropathy) monitored at 8%.
- In 2006, the Maryland HMO/POS averages for these measures ranged from 22% to 91%.
- The average rate for the Maryland specific combination measure was 22%; plan rates ranged from 15%–43%, with one plan receiving an above average score, four plans receiving average scores, and two plans receiving below-average scores.

In 2006, health plan rates varied widely within each of the eight *Comprehensive Diabetes Care* measures, as follows.

Table 20: Variation in Plan Results for Comprehensive Diabetes Care, 2006

Measure	Highest Plan Rate (%)	Lowest Plan Rate (%)
Blood Glucose Testing	90	83
Blood Glucose Control	77	66
Cholesterol Testing	93	90
Cholesterol Control: <100 mg/dL	55	40
Cholesterol Control: <130 mg/dL	77	63
Eye Exams	67	53
Monitoring Diabetic Nephropathy	70	51
Combination Rate	43	15

Table 21

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Testing, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**83%**	**85%**	**85%**	**2%**			
Aetna[r]	80%	86%	86%	↑	★★	★★	★★
BlueChoice	81%	82%	83%	⇔	★★	★★	★★
CIGNA	87%	90%	90%	⇔	★★★	★★★	★★★
Coventry[r]	80%	84%	84%	⇔	★★	★★	★★
Kaiser Permanente[r]	85%	85%	85%	⇔	★★	★★	★★
M.D. IPA[r]	86%	85%	85%	⇔	★★★	★★	★★
OCI[r]	82%	83%	83%	⇔	★★	★★	★★

Table 22

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Control, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**70%**	**70%**	**71%**	**1%**			
Aetna[r]	64%	67%	67%	⇔	★	★★	★★
BlueChoice	66%	59%	70%	⇔	★★	★	★★
CIGNA	74%	76%	73%	⇔	★★★	★★★	★★
Coventry[r]	67%	66%	66%	⇔	★★	★★	★
Kaiser Permanente[r]	73%	77%	77%	⇔	★★	★★★	★★★
M.D. IPA[r]	73%	73%	73%	⇔	★★	★★	★★
OCI[r]	70%	70%	70%	⇔	★★	★★	★★

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2006 and this plan elected to resubmit 2005 data in 2006.

Table 23

Comprehensive Diabetes Care, Cholesterol (LDL-C) Testing, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**89%**	**91%**	**91%**	**2%**			
Aetna	88%	93%	90%	⇔	★★	★★★	★★
BlueChoice	88%	91%	91%	⇔	★★	★★	★★
CIGNA	92%	93%	93%	⇔	★★★	★★	★★
Coventry[r]	86%	91%	91%	🡅	★★	★★	★★
Kaiser Permanente[r]	90%	91%	91%	⇔	★★	★★	★★
M.D. IPA	91%	89%	91%	⇔	★★★	★★	★★
OCI	86%	88%	90%	⇔	★★	★★	★★

Note: The range of rates is very narrow. This measure has stabilized just as rates for the Breast Cancer Screening and Cervical Cancer Screening measures have.

Table 24

Comprehensive Diabetes Care, Cholesterol (LDL-C) <100 mg/dL Control, Trending							
	Comparison of Actual Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**38%**	**45%**	**49%**	**11%**			
Aetna	36%	38%	43%	🡅	★★	★	★
BlueChoice	37%	44%	54%	🡅	★★	★★	★★★
CIGNA	37%	47%	47%	🡅	★★	★★	★★
Coventry[r]	38%	40%	40%	⇔	★★	★	★
Kaiser Permanente[r]	50%	55%	55%	⇔	★★★	★★★	★★★
M.D. IPA	36%	46%	52%	🡅	★★	★★	★★
OCI	33%	47%	50%	🡅	★	★★	★★

Legend

Change 2004–2006

- 🡅 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡇 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2006 and this plan elected to resubmit 2005 data in 2006.

Table 25

Comprehensive Diabetes Care, Cholesterol (LDL-C) <130 mg/dL Control, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**64%**	**69%**	**72%**	**8%**			
Aetna	63%	66%	70%	⇑	★★	★★	★★
BlueChoice	62%	69%	72%	⇑	★★	★★	★★
CIGNA	64%	71%	72%	⇑	★★	★★	★★
Coventry[r]	61%	63%	63%	⇔	★★	★	★
Kaiser Permanente[r]	78%	77%	77%	⇔	★★★	★★★	★★★
M.D. IPA	63%	71%	75%	⇑	★★	★★	★★
OCI	58%	70%	74%	⇑	★	★★	★★

Table 26

Comprehensive Diabetes Care, Eye Exams, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**53%**	**55%**	**57%**	**4%**			
Aetna	48%	50%	54%	⇔	★	★	★★
BlueChoice[r]	49%	55%	55%	⇔	★★	★★	★★
CIGNA	48%	51%	53%	⇔	★	★★	★
Coventry[r]	52%	55%	55%	⇔	★★	★★	★★
Kaiser Permanente[r]	73%	66%	66%	⇓	★★★	★★★	★★★★
M.D. IPA	54%	62%	67%	⇑	★★	★★★	★★★
OCI	43%	48%	53%	⇑	★	★	★

Legend

Change 2004–2006

⇑ Plan rate increased significantly from 2004 to 2006.
⇔ Plan rate *did not* change significantly from 2004 to 2006.
⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2006 and this plan elected to resubmit 2005 data in 2006.

Table 27

Comprehensive Diabetes Care, Monitoring Diabetic Nephropathy, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**48%**	**53%**	**56%**	**8%**			
Aetna	38%	46%	51%	↑	★	★	★
BlueChoice[r]	42%	52%	52%	↑	★	★★	★★
CIGNA	55%	61%	54%	⇔	★★★	★★★	★★
Coventry[r]	49%	55%	55%	⇔	★★	★★	★★
Kaiser Permanente[r]	78%	70%	70%	↓	★★★	★★★	★★★★
M.D. IPA	38%	45%	56%	↑	★	★	★★
OCI	36%	40%	53%	↑	★	★	★★

Table 28

Comprehensive Diabetes Care MHCC- Specific Combination Rating, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**20%**	**21%**	**22%**	**2%**			
Aetna	14%	17%	18%	⇔	★	★	★★
BlueChoice	13%	19%	19%	↑	★	★★	★★
CIGNA	21%	24%	21%	⇔	★★	★★	★★
Coventry	19%	15%	15%	⇔	★★	★	★
Kaiser Permanente	48%	43%	43%	⇔	★★★	★★★	★★★
M.D. IPA	12%	16%	19%	↑	★	★	★★
OCI	12%	12%	16%	⇔	★	★	★

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2006 and this plan elected to resubmit 2005 data in 2006.

Table 29

Comprehensive Diabetes Care, 2006 Results																		
	Blood Glucose (HbA1c) Testing		Blood Glucose (HbA1c) Control		Cholesterol Testing		Cholesterol Control <100 mg/dL		Cholesterol Control <130 mg/dL		Eye Exams		Monitoring Diabetic Nephropathy		MHCC-specific Combination Measure	
Maryland HMO/POS Average	**85%**		**71%**		**91%**		**49%**		**72%**		**57%**		**56%**		**22%**	
Aetna	86%	★★	67%	★★	90%	★★	43%	★	70%	★★	54%	★★	51%	★	18%	★★
BlueChoice	83%	★★	70%	★★	91%	★★	54%	★★★	72%	★★	55%	★★	52%	★★	19%	★★
CIGNA	90%	★★★	73%	★★	93%	★★	47%	★★	72%	★★	53%	★	54%	★★	21%	★★
Coventry	84%	★★	66%	★	91%	★★	40%	★	63%	★	55%	★★	55%	★★	15%	★
Kaiser Permanente	85%	★★	77%	★★★	91%	★★	55%	★★★	77%	★★★	66%	★★★★	70%	★★★★	43%	★★★
M.D. IPA	85%	★★	73%	★★	91%	★★	52%	★★	75%	★★	67%	★★★	56%	★★	19%	★★
OCI	83%	★★	70%	★★	90%	★★	50%	★★	74%	★★	53%	★	53%	★★	16%	★

Legend

Relative Rates

★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).

★★★ = Plan performed significantly better than the Maryland HMO/POS average.

★★ = Plan performed equivalent to the Maryland HMO/POS average.

★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

Background

Asthma is one of the nation's most common and costly conditions. According to the American Lung Association (2006), over 30 million people suffer from asthma, including over 8.5 million children (2004). It is the sixth leading chronic condition in the United States and the most common chronic disease in children. In 2004, asthma accounted for 1 million hospital outpatient visits, 1.8 million emergency department visits, and 13.6 million doctors visits (American Lung Association, 2006). Asthma can be life-threatening. Nearly 5,000 people die each year from poor management of the disease. Specific medications such as corticosteroids are considered the most effective therapy to control persistent asthma.

Asthma is one of the most prevalent diseases in Maryland. Surveillance data from 2004 showed that 11.9% of adults and 11.1% of children had asthma. In 2003, 9,000 residents were hospitalized and 38,000 residents were treated in emergency rooms, costing $41 million and $28 million, respectively. Blacks, low-income residents, and those living in certain jurisdictions, such as Baltimore City, were found to have a higher risk for asthma. Asthmatics in Maryland perceived their general health less favorably than non-asthmatics, and reported that it affects their quality of life (Maryland Asthma Control Program, 2004). Perhaps the lack of adequate treatment that some residents receive contributes to their poor health. A recent study completed by the Maryland Health Care Commission assessed the use of appropriate medications for privately-insured asthmatic children. The study found that though inhaled corticosteroids are the preferred medication for managing persistent asthma, 36% of children having this classification of asthma did not receive the medication during the year. This suggests that for many children with severe asthma, the care they receive from their health plans does not conform to guidelines for best practices in asthma treatment.

Measure Definition

The *Use of Appropriate Medications for People with Asthma* measure shows the percentage of members ages 5–56 years with persistent asthma, who were continuously enrolled during 2004 and 2005 and who were prescribed medications acceptable as primary therapy for long-term control of asthma. People with persistent asthma are defined by HEDIS as having had *any* of the following during 2005 and 2004.

- At least four asthma medication dispensing events, ***or***
- At least one emergency department visit with asthma as the principal diagnosis, ***or***
- At least one hospitalization with asthma as the principal diagnosis, ***or***
- At least four outpatient visits with asthma as one of the listed diagnoses and a minimum of two asthma medication dispensing events.

The medications identified as acceptable primary therapy are listed on NCQA's Web site, www.ncqa.org.

HEDIS 2006 measure results are reported for four age groups.

- Ages 5–9 years
- Ages 10–17 years
- Ages 5–17 years (children)
- Ages 18–56 years (adults)

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes to HEDIS 2006

The definition of persistent asthma was changed. Members must meet one of the four specified criteria during the measurement year and the year prior to the measurement year in order to be included in the denominator. Because changes in specification change the eligible population, this measure is not trendable.

Star Performer

This measure is not reported in the *2006/2007 Consumer Guide;* therefore, it is not eligible for Star Performer designation.

Note

Changes introduced in HEDIS 2006 resulted in more accurate identification of the eligible population. As a result, numerator and denominator shifts produced an average increase of 18 percentage points across Maryland plans from 2005 to 2006.

Results *(see Tables 30-32)*

Results are broken down into two age groups: 5–17 years and 18–56 years.

- For 2006, the Maryland HMO/POS average for the 5-17 age group (94%) was very similar to the average for the 18-56 age group (93%).
- For the 5-17 age group, one plan received an above-average score, five plans received average scores, and one plan received a below-average score.
- For the 18-56 age group, two plans received above-average scores, two plans average scores, and three plans below-average scores.

Results are also presented for ages 5–9 years, ages 10–17 years, and the total population across all age groups (combined rate).

- For 2006, the Maryland HMO/POS average for the combined age group was 93%.
- For the 5–9 years age group, one plan received a rate of 100%.

Table 30

Use of Appropriate Medications for People With Asthma - Ages 5-17, Trending						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2004	2005	2006	2004	2005	2006
Maryland HMO/POS Average	**69%**	**73%**	**94%**			
Aetna	67%	69%	90%	★★	★	★
BlueChoice	65%	81%	95%	★	★★★	★★
CIGNA	66%	73%	95%	★★	★★	★★
Coventry	72%	76%	96%	★★	★★	★★
Kaiser Permanente	NR[a]	68%	96%	NR[a]	★	★★★
M.D. IPA	70%	70%	93%	★★	★	★★
OCI	72%	72%	94%	★★★	★★	★★

Table 31

Use of Appropriate Medications for People With Asthma - Ages 18-56, Trending						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2004	2005	2006	2004	2005	2006
Maryland HMO/POS Average	**74%**	**76%**	**93%**			
Aetna	72%	74%	88%	★★	★	★
BlueChoice	73%	85%	98%	★★	★★★	★★★
CIGNA	70%	74%	90%	★	★★	★
Coventry	73%	79%	93%	★★	★★	★★
Kaiser Permanente	NR[a]	72%	97%	NR[a]	★	★★★
M.D. IPA	77%	76%	92%	★★★	★★	★★
OCI	76%	75%	91%	★★★	★★	★

Legend

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- NR[a] = Not Reportable. Underlying data contained errors.

Table 32

Use of Appropriate Medications for People With Asthma, 2006 Results								
	Ages 5-9		Ages 10-17		Ages 5-17		Ages 18-56	
Maryland HMO/POS Average	**95%**		**92%**		**94%**		**93%**	
Aetna	92%	★	87%	★	90%	★	88%	★
BlueChoice	95%	★★	96%	★★★	95%	★★	98%	★★★
CIGNA	95%	★★	94%	★★	95%	★★	90%	★
Coventry	100%	★★★	90%	★★	96%	★★	93%	★★
Kaiser Permanente	95%	★★	97%	★★★	96%	★★★	97%	★★★
M.D. IPA	95%	★★	90%	★★	93%	★★	92%	★★
OCI	95%	★★	93%	★★	94%	★★	91%	★

Legend

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

FLU SHOTS FOR ADULTS AGES 50–64

Background

More than 200,000 people in the United States are hospitalized for flu-related complications each year (Thompson et al., 2004). Influenza-related morbidity and mortality among middle-aged adults is particularly significant. Of the 20,000 influenza-associated deaths per year, about 9% occur among people ages 50–64 (CDC, 2004). Adults in this age group are particularly vulnerable because one-third of them have one or more chronic medical conditions that put them at increased risk for serious flu complications (CDC, 2006). A study has shown that influenza vaccination among this age group has decreased rates of influenza illness, work absenteeism, and need for medical services (Bridges et al., 2000).

Influenza vaccination is the primary method for preventing flu and its severe complications. The Advisory Committee on Immunization Practices recommends an annual vaccination for the following risk groups (ACIP, MMWR, 2006).

- People at increased risk for influenza-related complications (i.e., ages ≥65 years, children ages 6–23 months, pregnant women, and people of any age with certain chronic medical conditions).
- People ages 50–64 years, as this group has an elevated prevalence of certain chronic medical conditions.
- People who live with or care for people at high risk (e.g., health-care workers and household contacts who have frequent contact with people at high risk and who can transmit influenza to those people).

For locations of public flu shot clinics this flu season, visit the Flu Shot Locator Web site, sponsored by the American Lung Association, at http://www.fluclinicslocator.org/.

Measure Definition

The *Flu Shots for Adults Ages 50-64* measure shows the percentage of members ages 50–64 years as of September 1, 2005, who received an influenza vaccination between September 2005 and the date on which the CAHPS 3.0H Adult Survey was completed.

Data Collection Methodology

This measure is collected through the CAHPS 3.0H survey.

Summary of Changes to HEDIS 2006

There were no significant changes.

Star Performer

This measure is not included in the *2006/2007 Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Notes

The measure is collected for two consecutive years to achieve a sufficient denominator. Results are calculated as a moving or rolling average using data collected during the measurement year and the year preceding the measurement year (i.e., the 2004 and 2005 data combine to form one rate).

The shortage of available flu vaccination in the United States during the 2004–2005 flu season contributed to the decline in vaccination rates in 2005. Although there was no shortage during the 2005–2006 flu season, the previous seasons' shortage and decline in vaccination rates affects the 2006 rate because of the rolling average calculation described above. Due to these circumstances, this measure is not trendable for 2004–2006.

Results *(see Tables 33-34)*

- In 2006, the Maryland HMO/POS average for members who received a flu shot was 36%, a 12 percentage point decrease from 2004.
- Rates ranged from 29%–45%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.
- On average, 52% of members reported that they did not ask for the flu shot, while 15% refused to get it. Thirteen percent of members said that the vaccine was not available.

Table 33

Flu Shots for Adults Ages 50-64, Results						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2004	2005	2006	2004	2005	2006
Maryland HMO/POS Average	**48%**	**39%**	**36%**			
Aetna	51%	48%	37%	★★	★★★	★★
BlueChoice	46%	36%	35%	★★	★★	★★
CIGNA	43%	30%	29%	★★	★	★
Coventry	47%	36%	33%	★★	★★	★★
Kaiser Permanente	51%	45%	45%	★★	★★★	★★★
M.D. IPA	52%	42%	41%	★★	★★	★★
OCI	46%	38%	33%	★★	★★	★★

Table 34

Reasons for Not Getting a Flu Shot, 2006 Results					
	Didn't ask	**Refused**	**Ineligible**	**Unavailable**	**Other**
Maryland HMO/POS Average	**52%**	**15%**	**3%**	**13%**	**18%**
Aetna	46%	18%	1%	11%	23%
BlueChoice	52%	12%	3%	20%	13%
CIGNA	48%	18%	4%	15%	14%
Coventry	53%	11%	0%	14%	23%
Kaiser Permanente	54%	16%	1%	8%	20%
M.D. IPA	55%	14%	4%	11%	16%
OCI	59%	14%	1%	11%	15%

Legend

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

PREVENTION AND EARLY DETECTION OF CANCER

Overview

Death rates from all cancers combined have been decreasing since the early 1990s; however, cancer is still the second leading cause of death in the United States. Nearly 50% of all men and approximately 33% of all women in the United States will develop cancer during their lifetime. The risk of developing most types of cancer can be reduced by changes in lifestyle, such as quitting smoking and better nutrition. The sooner a cancer is found and treatment begins, the better the chances of survival (American Cancer Society, 2005).

Trends in Cancer

The nation's leading cancer organizations have collaborated to report on the occurrence and trends of cancer in the United States. The *Annual Report to the Nation on the Status of Cancer, 1975–2001* reported that Americans' risk of getting and dying from cancer continues to decline and survival rates for many cancers continue to improve. Findings show overall cancer incidence rates dropped 0.5% per year from 1991–2001, while death rates from all cancers combined dropped 1.1% per year from 1993–2001. Rates of death caused by 11 of the top 15 most prevalent cancers in men and 8 of the top 15 most prevalent cancers in women have decreased, although the rate of death related to lung cancer leveled off for women for the first time between 1995 and 2001. According to the report's authors, new data reflect progress in prevention, early detection, and treatment; however, not all segments of the population have benefited equally from the advances (National Cancer Institute, 2004).

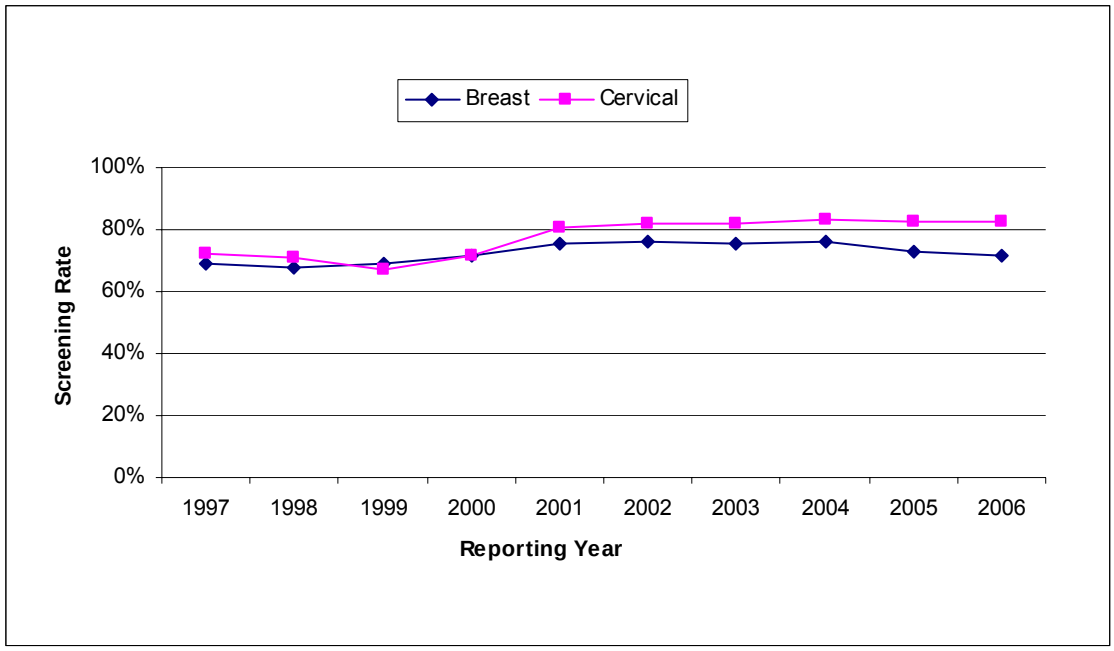
> *Death rates for Maryland have decreased at a faster rate since 1990 and are now equal to the national average (National Cancer Institute, 2002).*

Cancer Screenings in Maryland

In Maryland, screening rates for breast and cervical cancer have generally increased for female members enrolled in commercial HMOs. The current reporting year marks the second consecutive year that breast cancer screening rates have declined, however, after a steady rate of 76% between 2002 and 2004. The 2006 average rate of breast cancer screening (71%) reflects a higher proportion of women receiving this care compared to the average rate in 1997 (69%). The rate for cervical cancer screening has remained stable at 83% for the past three years.

The remainder of this section details how often Maryland HMO members receive recommended cancer screenings and advice to quit smoking.

Table 35: Cancer Screening, Maryland 1997-2006



COLORECTAL CANCER SCREENING

Background

Colorectal cancer is the third most common cancer among men and women in the United States. According to the American Cancer Society, 148,610 new cases will be diagnosed in 2006.

> *An average of 26.9 male and 19.3 female Marylanders per 100,000 died annually from the disease between 1998 and 2002 (American Cancer Society, 2006).*

Colorectal cancer develops slowly and is often asymptomatic in its early stages. The risk of colorectal cancer increases with age. More than 90% of all diagnosed individuals are over the age of 50 (CDC, Cancer Prevention and Control) and less than 30% of colorectal cancer cases are associated with evidence of having inherited the disorder (American Cancer Society, 2006).

Measure Definition

The *Colorectal Cancer Screening* measure shows the percentage of adults ages 50–80 years who had appropriate screening for colorectal cancer.

Data Collection Methodology

This measure is collected using the hybrid methodology.

Summary of Changes to HEDIS 2006

There were no significant changes.

Star Performer

This measure was reported in the *2006/2007 Consumer Guide*; therefore, it is eligible for Star Performer designation.

Notes

For this measure, the numerator includes one or more screenings for colorectal cancer. Appropriate screenings must meet one of four criteria, although a person can meet more than one criterion.

- Fecal occult blood test (FOBT) during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

Results *(see Table 36)*

- From 2004–2006, the Maryland HMO/POS average increased 6 percentage points to 55%.
- In 2006, rates ranged from 52%–60%, with two plans receiving above-average scores, two plans receiving average scores, and three plans receiving below-average scores.
- Six plans saw significant increases in their rates. One plan received a Star Performer designation for this measure.

Table 36

Colorectal Cancer Screening, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**49%**	**53%**	**55%**	**6%**			
Aetna[m]	44%	49%	52%	↑	★	★	★
BlueChoice	52%	62%	54%	⇔	★★	★★★	★★
CIGNA	52%	53%	60%	↑	★★	★★	★★★
Coventry[m]	49%	49%	56%	↑	★★	★	★★
Kaiser Permanente[m]	49%	50%	53%	↑	★★	★	★
M.D. IPA[m]	52%	55%	59%	↑	★★★	★★★	★★★★
OCI[m]	47%	50%	53%	↑	★	★	★

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [m]This plan used the administrative method to calculate this rate.

BREAST CANCER SCREENING

Background

Among women in the United States, breast cancer ranks as the second leading cause of cancer deaths. An estimated 212,920 new cases and 40,970 deaths are anticipated in 2006. Due to increased awareness, earlier detection, and improved treatment, breast cancer mortality rates declined, on average, 2.3% per year from 1990–2002 (American Cancer Society, 2006).

> *From 1998–2002, 28.5 females in Maryland per 100,000 died annually from breast cancer (American Cancer Society, 2006).*

When high-quality equipment is used and x-rays are read by well-trained radiologists, 85%–90% of cancers are detectable (U.S. Preventive Services Task Force). For women ages 40–49 years, mammography can reduce ten-year mortality by 20%–25% (CDC, 2006). The USPSTF (2002) recommends screening mammography, with or without clinical breast examination, every one to two years for women age 40 years and older. The task force found fair evidence that mammography screening every 12–33 months significantly reduces mortality from breast cancer; particularly for women ages 50–69 years.

> *In 2004, approximately 75% of American women age 40 and older reported that they had a mammogram in the past two years. In Maryland, this figure was 79%, a statistically significant difference from the national average (CDC, BRFSS 2006).*

Though there are clear guidelines about who should receive breast cancer screening, disparities exist. Studies have shown that breast cancer screening occurs disproportionately based on race, ethnicity, and socioeconomic status. Any disparity in health care services can lead to higher mortality rates. The National Cancer Institute reports that Black women experience higher death rates than White women, although White women have a higher incidence of breast cancer. Between 1998 and 2002, there were 119.4 breast cancer incidences per 100,000 Black women, compared to 141.1 incidences for White women, but there were 34.7 deaths resulting from this for Black women, compared to 25.9 deaths for White women (NCI, 2005). The Office of Minority Health at the CDC suggests that the disproportionately high burden of breast cancer in Black women is due to inadequate screening and follow-up treatment, which results from limited access or knowledge about how to access screening and cancer treatment services. The disparity in screening and treatment seen in other racial and cultural groups is due to limited access to health care services and language and cultural barriers.

The National Cancer Institute suggests that disparities in cancer screening and deaths may be due to differences in socio-economic status, rather than age. This is supported by a study released by the CDC in 2005, which showed that the geographic areas in which persons live may be related to their level of screening uses, based upon how they affect income, education, employment, access to health care, and other related factors. These environmental factors are related to one's socioeconomic status.

Strategies to mitigate these disparities include providing screening to minorities in their communities, facilitating cultural competence in clinicians, and increasing health education and awareness among women and communities.

Measure Definition

The *Breast Cancer Screening* measure shows the percentage of women ages 50–69 years who were continuously enrolled during 2004 and 2005 and who had at least one mammogram during those years.

> *In HEDIS 2007, the specifications for this measure will change to include a decrease in the lower age limit, from 50 to 40 years of age, and an increase in the upper age limit, from 69 to 74 years of age.*

Data Collection Methodology

This measure is collected using the administrative methodology. The hybrid methodology was retired in HEDIS 2006.

Summary of Changes to HEDIS 2006

The hybrid method was retired. Due to this change in data collection methodology, data for this measure is not trendable, as it may have caused a decrease in rates.

Star Performer

This measure was reported in the *2006/2007 Consumer Guide;* therefore, it is eligible for Star Performer designation.

Results *(see Table 37)*

- In 2006, rates ranged from 68%–78%, with three plans receiving above-average scores and four plans receiving below-average scores.
- One plan received a star performer designation for this measure and was the only plan to receive an above-average score in each of the three years.

Table 37

Breast Cancer Screening						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2004	2005	2006	2004	2005	2006
Maryland HMO/POS Average	**76%**	**73%**	**71%**			
Aetna	71%	70%	68%	★	★★	★
BlueChoice	76%	70%	71%	★★	★★	★
CIGNA	77%	74%	69%	★★	★★	★
Coventry	86%	78%	73%	★★★	★★★	★★★★
Kaiser Permanente	76%	75%	78%	★★	★★	★★★
M.D. IPA	76%	76%	73%	★★	★★	★★★
OCI	70%	70%	68%	★	★★	★

Legend

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

CERVICAL CANCER SCREENING

Background

When detected and treated early, cervical cancer can often be cured. The five-year survival rate for early-stage cervical cancer is 91%. The American Cancer Society (2006) estimates 9,710 new cases of cervical cancer and 3,700 deaths to occur as a result of the disease in 2006.

Between 1955 and 1992, the number of cervical cancer deaths in the United States dropped by 74% and continues to decline each year by about 4%. This decline is largely attributed to increased use of the Pap test. A woman who is screened every two years reduces her chances of getting cervical cancer by 86%–91%, compared to 61%–74% if she has five Pap tests in her lifetime (ACCP, 2003).

Similar to the trend seen with breast cancer rates, disparities also exist for cervical cancer. The National Cancer Institute reports that between 1998 and 2002, the prevalence of cervical cancer among different races and ethnicities of women varied per 100,000 females, as follows.

- Asian/Pacific Islander (8.9)
- American Indian/Alaskan native (4.9)
- Hispanic/Latina (15.8)
- Black (11.1)
- Non-Hispanic White (8.7)

In June 2006, the Food and Drug administration licensed a new vaccine, Gardasil, which will be made available to adolescents and women ages 9–26 years to prevent infection with the strains of human papillomavirus (HPV) that cause most cervical cancers and other diseases, such as precancerous genital lesions and genital warts. Gardasil is effective only in people who have never been infected with the particular strains of HPV that cause cervical cancer, and it does not protect against the more common strains of HPV that are not included in the vaccine, so regular pap smears are still recommended. The discovery and licensing of this vaccine marks a major progress in the fight against cervical cancer, as it will significantly reduce the incidence of a certain cancer. Studies conducted to test the effectiveness of Gardasil showed that in women who had not already been infected, Gardasil was almost 100% effective in preventing precancerous cervical lesions, precancerous vaginal and vulvar lesions, and genital warts caused by the types of HPV strains that the vaccine is intended to target (FDA, 2006).

Measure Definition

The *Cervical Cancer Screening* measure shows the percentage of women ages 18–64 years who were continuously enrolled during 2003–2005 and who received one or more Pap tests during those years.

> *In HEDIS 2007, the specifications for this measure may change to raise the lower age limit, from 18 to 21 years of age.*

Data Collection Methodology

This measure is collected using either the administrative or the hybrid methodology and is eligible for rotation in HEDIS 2006.

Summary of Changes to HEDIS 2006

There were no significant changes.

Star Performer

This measure is not reported in the *2006/2007 Consumer Guide;* therefore, it is not eligible for Star Performer designation.

Results *(see Table 38)*

- From 2004–2006, the Maryland HMO/POS average remained the same (83%).
- A decline in performance was shown for one plan, while the remaining six plans showed no statistically significant differences in their rates over time.
- In 2006, rates ranged from 81%–85%, with all but one plan receiving average scores.
- Only one plan received a below-average score, and this score reflected a significant decrease.

Table 38

Cervical Cancer Screening, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**83%**	**83%**	**83%**	**0%**			
Aetna[r]	85%	85%	85%	⇔	★★	★★	★★
BlueChoice	80%	83%	84%	⇔	★	★★	★★
CIGNA	82%	83%	84%	⇔	★★	★★	★★
Coventry[r]	81%	82%	82%	⇔	★★	★★	★★
Kaiser Permanente[m]	84%	83%	81%	🡻	★★★	★★	★
M.D. IPA[r]	83%	83%	83%	⇔	★★	★★	★★
OCI[r]	85%	81%	81%	⇔	★★	★★	★★

Legend

Change 2004–2006

- 🡹 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡻 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- **[m]** This plan used the administrative method to calculate this rate.
- **[r]** This measure was eligible for rotation in 2006 and this plan elected to resubmit 2005 data in 2006.

MEDICAL ASSISTANCE WITH SMOKING CESSATION

Background

Smoking is the leading preventable cause of death in the United States, causing more than 442,000 deaths each year. On average, smokers' lives are cut short by over 13 years (CDC, 2005b). Despite the health risks and detrimental effect smoking has on every organ in the body, an estimated 44.5 million Americans currently smoke (Fiore, Bailey, & Cohen, 2000).

Medical assistance with smoking cessation can improve the quit rate. Research shows that physician counseling for smoking cessation without the use of medications results in an estimated 1.8 million new quitters. Smoking cessation treatment doubles quitting success rates (Fiore et al., 2000); however, among current smokers and former smokers who were trying to quit and had seen a health care provider, only 61.8% received advice to quit from those providers (Cokkinides, Ward, Jemal, & Thun, 2005).

Measure Definition

Three components make up the *Medical Assistance with Smoking Cessation* measure.

1. **Advising Smokers to Quit** shows the percentage of members age 18 years and older who are current smokers and whose practitioners advised them to quit smoking.
2. **Discussing Smoking Cessation Medications** shows the percentage of members age 18 years and older who are current smokers and whose practitioners recommended or discussed smoking cessation medications.
3. **Discussing Smoking Cessation Strategies** shows the percentage of members age 18 years and older who are current smokers and whose practitioners recommended or discussed smoking cessation methods or strategies.

Data Collection Methodology

This measure is collected through the CAHPS 3.0H survey.

Summary of Changes to HEDIS 2006

- Recent quitters were removed from the denominator of all three rates.
- Two questions that were previously used to identify recent quitters were removed.

Star Performer

The *Advising Smokers to Quit* measure is included in the *2006/2007 Consumer Guide;* therefore, it is eligible for Star Performer designation.

Notes

The measure is collected for two consecutive years to achieve a sufficient denominator. Results are calculated as a moving or rolling average using data collected during the measurement year and the year preceding the measurement year (i.e., the 2004 and 2005 data combine to form one rate).

Results *(see Tables 39-41)*

- In 2006, 73% of members who were current smokers received a practitioner's advice to quit, compared to 37% who reported that their doctor recommended or discussed cessation medications or strategies.
- These results show that although plan members are being advised to quit smoking, about one-third are given medications and strategies to aid them in quitting.
- No plan saw any significant change in its performance between 2004 and 2006.

Table 39

Advising Smokers to Quit, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**73%**	**73%**	**73%**	**0%**			
Aetna	73%	69%	67%	⇔	★★	★★	★★
BlueChoice	74%	76%	75%	⇔	★★	★★	★★
CIGNA	69%	74%	71%	⇔	★★	★★	★★
Coventry	70%	73%	76%	⇔	★★	★★	★★
Kaiser Permanente	72%	72%	76%	⇔	★★	★★	★★
M.D. IPA	78%	81%	76%	⇔	★★	★★★	★★
OCI	73%	67%	67%	⇔	★★	★★	★★

Legend

Change 2004–2006

- ⇑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 40

Discussing Smoking Cessation Medications, Results				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2005	2006	2005	2006
Maryland HMO/POS Average	**41%**	**37%**		
Aetna	42%	37%	★★	★★
BlueChoice	42%	44%	★★	★★
CIGNA	38%	33%	★★	★★
Coventry	41%	37%	★★	★★
Kaiser Permanente	33%	35%	★	★★
M.D. IPA	50%	41%	★★★	★★
OCI	40%	36%	★★	★★

Table 41

Discussing Smoking Cessation Strategies, Results				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2005	2006	2005	2006
Maryland HMO/POS Average	**41%**	**37%**		
Aetna	39%	31%	★★	★★
BlueChoice	39%	39%	★★	★★
CIGNA	45%	35%	★★	★★
Coventry	34%	39%	★	★★
Kaiser Permanente	37%	43%	★★	★★
M.D. IPA	54%	40%	★★★	★★
OCI	39%	33%	★★	★★

Legend

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

ACCESS/AVAILABILITY OF CARE

ACCESS/AVAILABILITY OF CARE

Overview

This section presents results for the measures in HEDIS 2006 *Access/Availability of Care* domain that MHCC required Maryland commercial HMOs to report in 2006. These measures listed below are designed to approximate the level of access members have to their health care delivery systems.

Measures in Domain

- Adults' Access to Preventive/Ambulatory Health Services
- Children and Adolescents' Access to Primary Care Practitioners
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Well-Child Visits for Infants and Children (Composite)
- Adolescent Well-Care Visits
- Prenatal and Postpartum Care

Measures Eligible for Rotation in HEDIS 2006

- Prenatal and Postpartum Care

Plans that rotated this measure are identified by the superscript "r" in the results tables.

Adults' Access, Children and Adolescents' Access

The *Adults' Access* and *Children and Adolescents' Access* measures report the percentage of the plan's population who saw a practitioner during a specified period of time. These measures provide a glimpse into the level of access members have to primary care services. It should be noted, however, that quantifying data completeness is particularly difficult since a number of factors can result in a lower-than-expected rate of visits. A low access rate could signify data submission issues with providers, barriers to care for members, member choice to not obtain services, or a healthy population that does not need much medical treatment. As rates approach 100%, the issue of data completeness becomes less likely.

Obtaining an accurate measurement of access to care is a continuing challenge in quality measurement. The measures in this section act as proxies for access and can provide valuable information to consumers, purchasers, policy makers, and other stakeholders, when considered with other information.

Well-Child and Adolescent Well-Care Visit Measures

These measures report information on a subset of members who were continuously enrolled in the health plan for a specified period of time and received routine care.

Prenatal and Postpartum Care

This measure includes timely initiation of prenatal care and check-ups after delivery.

ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES

Background

The first U.S. Preventive Services Task Force (USPSTF) recommends that even healthy adults receive some important preventive services at least once every three years (*Guide to Clinical Preventive Services,* 2005). Preventive health visits require height and weight measurement during each preventive visit as well as various screenings, depending on the age and medical history of the adult, to detect disease early. Access to primary care has been shown to correlate with reduced hospital use while preserving quality (Bindham, 1995; Bodenheimer, 2005).

Annually, 7 out of 10 (or more than 1.7 million) deaths in the United States are due to chronic diseases. More and more Americans are diagnosed with diabetes, heart disease, stroke, and cancer. Maryland death and disability rates also follow this trend, with 28% of deaths due to heart disease alone in 2001 (CDC, 2006). Disease trends such as these increase the need for adults to have access to routine preventive and ambulatory health services. Because many chronic diseases are generally due to behavioral risk factors (such as smoking, poor nutrition, and lack of physical activity), preventive health services provide an opportunity for educational intervention and screening services. High blood pressure and high cholesterol, the two major risk factors for heart disease and stroke, are conditions that can be easily monitored and controlled when patients have adequate access to providers.

Measure Definition

The *Adults' Access To Preventive/Ambulatory Health Services* measure shows the percentage of members ages 20–44 years and 45–64 years who had at least one ambulatory or preventive care visit during 2004–2006.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes to HEDIS 2006

There were no significant changes to this measure.

Star Performer

This measure is not reported in the *2006/2007 Consumer Guide* because rates have remained consistently level; therefore, it is not eligible for Star Performer designation.

Notes

The relatively high number of plans considered above or below average is partially a result of the fact that this measure is calculated on administrative data only. *Since samples are not used, the number of people who meet criteria for the measure is relatively large and confidence intervals are small, increasing the likelihood that variations in plan rates will represent statistically significant changes.*

Results

Ages 20–44 (see Table 42)

- In 2006, rates ranged from 91%–95%, as they did in 2004 and 2005. Three plans received above-average scores and four plans received below-average scores.

Ages 45–64 (see Table 43)

- In 2006, rates ranged from 93%–96%, with three plans receiving above-average scores and four plans receiving below-average scores.

Combined Measure: Ages 20-64 (see Table 44)

- The average rate for all adults' access to care (20–64 years) was 94%.
- Similar to the rate ranges in specific age groups, the overall rate showed little variation across plans. Rates varied by 3 percentage points, from 92%–95%.

Table 42

Adults' Access to Preventive/Ambulatory Health Services, Ages 20-44							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**92%**	**93%**	**93%**	**1%**			
Aetna	91%	91%	91%	⇑	★	★	★
BlueChoice	91%	91%	92%	⇑	★	★	★
CIGNA	91%	92%	91%	⇔	★	★	★
Coventry	95%	95%	95%	⇔	★★★	★★★	★★★
Kaiser Permanente	93%	94%	94%	⇑	★★★	★★★	★★★
M.D. IPA	93%	93%	93%	⇑	★★★	★★★	★★★
OCI	91%	92%	92%	⇑	★	★	★

Table 43

Adults' Access to Preventive/Ambulatory Health Services, Ages 45-64							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**94%**	**94%**	**95%**	**1%**			
Aetna	92%	93%	93%	⇑	★	★	★
BlueChoice	93%	94%	94%	⇑	★	★	★
CIGNA	93%	94%	94%	⇑	★	★	★
Coventry	96%	96%	96%	⇔	★★★	★★★	★★★
Kaiser Permanente	95%	95%	95%	⇑	★★★	★★★	★★★
M.D. IPA	95%	95%	96%	⇑	★★★	★★★	★★★
OCI	93%	93%	94%	⇑	★	★	★

Legend

Change 2004–2006

- ⇑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period. Plans used the administrative method to collect this measure, which increases the likelihood that variations in plan rates are statistically significant.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 44

Adults' Access to Preventive/Ambulatory Health Services, Combined Ages 20-64							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**93%**	**93%**	**94%**	**1%**			
Aetna	92%	92%	92%	↑	★	★	★
BlueChoice	92%	93%	93%	↑	★	★	★
CIGNA	92%	93%	93%	↑	★	★	★
Coventry	95%	96%	95%	⇔	★★★	★★★	★★★
Kaiser Permanente	94%	95%	95%	↑	★★★	★★★	★★★
M.D. IPA	94%	94%	94%	↑	★★★	★★★	★★★
OCI	92%	92%	93%	↑	★	★	★

Table 45

Adults' Access to Preventive/Ambulatory Health Services, All Measures, 2006 Results						
	20-44 Years		**45-64 Years**		**20-64 Years**	
Maryland HMO/POS Average	**93%**		**95%**		**94%**	
Aetna	91%	★	93%	★	92%	★
BlueChoice	92%	★	94%	★	93%	★
CIGNA	91%	★	94%	★	93%	★
Coventry	95%	★★★	96%	★★★	95%	★★★
Kaiser Permanente	94%	★★★	95%	★★★	95%	★★★
M.D. IPA	93%	★★★	96%	★★★	94%	★★★
OCI	92%	★	94%	★	93%	★

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period. Plans used the administrative method to collect this measure, which increases the likelihood that variations in plan rates are statistically significant.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS

Background

Similar to the *Adults' Access to Preventive/Ambulatory Health Services* measure, this measure shows a minimum level of access to care. It examines whether children and adolescents had at least one visit to a primary care practitioner.

Measure Definition

The *Children and Adolescents' Access to Primary Care Practitioners* measure shows the percentage of the following.

- Children ages 12–24 months and 25 months–6 years who were continuously enrolled in 2005 and who had at least one visit to a primary care practitioner during 2005.
- Children ages 7–11 years and adolescents ages 12–19 years who were continuously enrolled during 2004 and 2005 and who had at least one visit to a primary care practitioner during 2004 or 2005.

All visits to pediatricians, family physicians, and other health plan primary care practitioners, including physician assistants and nurse practitioners, are counted for this measure.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes to HEDIS 2006

There were no significant changes.

Star Performer

This measure is not reported in the *2006/2007 Consumer Guide* because rates have remained consistently level with all plans reporting high rates; therefore, it is not eligible for Star Performer designation.

Notes

The relatively high number of plans considered above or below average is partially a result of the fact that this measure is calculated on administrative data only. *Since samples are not used, the number of people who meet criteria for the measure is relatively large and confidence intervals are small, increasing the likelihood that variations in plan rates are statistically significant.*

Results

Ages 12–24 Months (see Table 46)

- Three plans had statistically significant increases in their rates, two plans had no significant increases in their rates, and two plans had significant decreases in their rates.
- In 2006, rates showed little variation compared to 2004 and 2005 rates. Rates in 2006 ranged from 97%–98%, with one plan receiving an above-average score and six plans receiving average scores.

Ages 25 Months–6 Years (see Table 47)

- For this age group, four plans had a statistically significant increase in their rates, two plans had no significant change in their rates, and one plan had a statistically significant decrease in its rate.
- In 2006, two plans received above-average scores, two plans received average scores, and three plans received below-average scores.

Ages 7–11 Years (see Table 48)

- Three plans received above-average scores and four plans received below-average scores.

Ages 12–19 Years (see Table 49)

- The Maryland HMO/POS average increased 1 percentage point in 2006 to 86%, with three plans receiving above-average scores, one plan receiving an average score, and three plans receiving below-average scores.

Table 46

Children's Access to Primary Care Practitioners, 12-24 Months							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**97%**	**97%**	**97%**	**0%**			
Aetna	97%	98%	98%	⇔	★★	★★★	★★
BlueChoice	96%	96%	98%	⇑	★	★	★★★
CIGNA	96%	96%	97%	⇑	★	★	★★
Coventry	97%	98%	97%	⇔	★★	★★★	★★
Kaiser Permanente	98%	97%	97%	⇓	★★★	★★	★★
M.D. IPA	96%	97%	97%	⇑	★	★★	★★
OCI	98%	98%	97%	⇓	★★★	★★	★★

Table 47

Children's Access to Primary Care Practitioners, 25 Months-6 Years							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**90%**	**89%**	**91%**	**1%**			
Aetna	89%	90%	91%	⇑	★	★★★	★★
BlueChoice	90%	90%	92%	⇑	★★	★★	★★★
CIGNA	90%	89%	91%	⇑	★★	★★	★★
Coventry	92%	92%	93%	⇔	★★★	★★★	★★★
Kaiser Permanente	92%	90%	90%	⇓	★★★	★★★	★
M.D. IPA	87%	87%	89%	⇑	★	★	★
OCI	88%	87%	89%	⇔	★	★	★

Legend

Change 2004–2006

- ⇑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period. Plans used the administrative method to collect this measure, which increases the likelihood that variations in plan rates are statistically significant.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 48

Children's Access to Primary Care Practitioners, 7-11 Years							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**90%**	**90%**	**90%**	**0%**			
Aetna	87%	88%	89%	↑	★	★	★
BlueChoice	90%	90%	92%	↑	★★	★★★	★★★
CIGNA	89%	90%	88%	↓	★★	★★★	★
Coventry	93%	93%	92%	⇔	★★★	★★★	★★★
Kaiser Permanente	92%	91%	90%	↓	★★★	★★★	★★★
M.D. IPA	88%	88%	88%	⇔	★	★	★
OCI	87%	87%	87%	⇔	★	★	★

Table 49

Adolescents' Access to Primary Care Practitioners, 12-19 Years							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**85%**	**86%**	**86%**	**1%**			
Aetna	82%	82%	83%	↑	★	★	★
BlueChoice	86%	86%	88%	↑	★★	★★★	★★★
CIGNA	86%	87%	86%	⇔	★★	★★★	★★
Coventry	88%	88%	88%	⇔	★★★	★★★	★★★
Kaiser Permanente	90%	89%	88%	↓	★★★	★★★	★★★
M.D. IPA	84%	83%	84%	⇔	★	★	★
OCI	83%	83%	83%	⇔	★	★	★

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period. Plans used the administrative method to collect this measure, which increases the likelihood that variations in plan rates are statistically significant.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 50

Children's and Adolescents' Access to Primary Care Practitioners, All Measures, 2006 Results								
	12-24 Months		25 Months-6 Years		7-11 Years		12-19 Years	
Maryland HMO/POS Average	**97%**		**91%**		**90%**		**86%**	
Aetna	98%	★★	91%	★★	89%	★	83%	★
BlueChoice	98%	★★★	92%	★★★	92%	★★★	88%	★★★
CIGNA	97%	★★	91%	★★	88%	★	86%	★★
Coventry	97%	★★	93%	★★★	92%	★★★	88%	★★★
Kaiser Permanente	97%	★★	90%	★	90%	★★★	88%	★★★
M.D. IPA	97%	★★	89%	★	88%	★	84%	★
OCI	97%	★★	89%	★	87%	★	83%	★

Legend

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

WELL-CHILD AND ADOLESCENT VISIT MEASURES

Background

Developmental milestones occur rapidly in the first year of life, when infants undergo substantial changes in physical growth and abilities. The American Academy of Pediatrics (AAP) recommends six well-child visits in the first year of life: the first within the first month of life and then at 2, 4, 6, 9, and 12 months.

Well-child visits during the preschool and early elementary school years are important to assess the extent to which children are reaching expected milestones, thereby increasing their chances of achieving their full potential. Through early detection and intervention, vision, speech, and language problems can be addressed. The AAP recommends annual well-child visits for 2 to 6 year-olds.

An annual preventive health care visit that addresses physical, emotional, and social aspects of health and promotes a healthy lifestyle, as well as disease prevention, is important for adolescents. During adolescence, dramatic physical and emotional changes take place. Unintentional injuries, homicide, and suicide are the leading causes of adolescent death (CDC, 2002). Other health-related issues such as sexually transmitted diseases (STD), substance abuse, pregnancy (84.5 per 1,000 adolescent females in 2000 [CDC, 2004]), and antisocial behavior can cause physical, emotional, and social problems for adolescents. The American Medical Association *Guidelines for Adolescent Preventive Services,* the federal government's Bright Futures program, and new AAP guidelines all recommend comprehensive annual check-ups for adolescents.

Measure Definition

Well-Child Visits in the First 15 Months of Life: This measure reports the percentage of children who turned 15 months old during 2005 and received *six or more* well-child visits by the time they reached 15 months of age.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life: This measure reports the percentage of children ages 3–6 years in 2005 who received *one or more* well-child visits with a primary care physician during the year.

Well-Child Visits for Infants and Children (Composite): This measure combines rates of well-child visits for infants ages birth–15 months and well-child visits for children ages 3–6 years to create one composite measure. Criteria remain the same as in the individual measures.

Adolescent Well-Care Visits: This measure reports the percentage of plan members ages 12–21 years who were continuously enrolled during 2005 and who received *at least one* well-care visit with a primary care practitioner or an obstetric/gynecological (OB/GYN) practitioner during the year.

Data Collection Methodology

These measures are collected using either the administrative or hybrid methodology.

Summary of Changes to HEDIS 2006

There were no significant changes.

Star Performer

The *Well-Child Visits for Infants and Children* (Composite) and *Adolescent Well-Care Visits* measures are reported in the *2006/2007 Consumer Guide;* therefore, they are eligible for Star Performer designation.

Notes

These measures are similar to the *Effectiveness of Care* measures in that higher rates indicate better performance. Trending and relative performance information is presented for these measures.

Results

Well-Child Visits in the First 15 Months of Life (see Table 51)

- From 2004–2006, the Maryland HMO/POS average increased 2 percentage points to 72%. One plan showed a 5 percentage point increase, more than twice the average increase across Maryland HMO/POS plans.
- Three of the seven plans showed statistically significant increases, three plans did not show any significant change, and one plan showed a statistically significant decrease in rate.
- In 2006, rates ranged from 62%–81%, with four plans receiving above-average scores and three plans receiving below-average scores.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (see Table 52)

- From 2004–2006, the Maryland HMO/POS average increased 4 percentage points to 73%.
- Five of the seven plans showed statistically significant increases, while two plans did not show any statistically significant change.
- In 2006, rates ranged from 69%–79%, with one plan receiving an above-average score, four plans receiving average scores, and two plans receiving below-average scores.

Well-Child Visits for Infants and Children (Composite) (see Table 53)

- From 2004–2006, the Maryland HMO/POS average increased 2 percentage points to 72%.
- Five of the seven plans showed statistically significant increases, while two plans did not show any statistically significant change.
- Two plans received Star Performer designations for this measure.

Adolescent Well-Care Visits (see Table 54)

- From 2004–2006, the Maryland HMO/POS average increased 2 percentage points to 39%.
- Four of the seven plans showed statistically significant increases, while three plans did not show any statistically significant changes.
- Two plans received Star Performer designations for this measure.

Table 51

Well-Child Visits in the First Fifteen Months, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**70%**	**72%**	**72%**	**2%**			
Aetna[m]	57%	60%	62%	↑	★	★	★
BlueChoice[m]	71%	75%	74%	↑	★★	★★★	★★★
CIGNA[m]	77%	79%	80%	↑	★★★	★★★	★★★
Coventry[m]	80%	82%	81%	⇔	★★★	★★★	★★★
Kaiser Permanente[m]	61%	61%	63%	⇔	★	★	★
M.D. IPA[m]	75%	73%	76%	⇔	★★★	★★	★★★
OCI[m]	73%	71%	71%	↓	★★★	★★	★

Table 52

Well-Child Visits in the 3rd, 4th, 5th, 6th Years, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**69%**	**70%**	**73%**	**4%**			
Aetna[m]	69%	71%	72%	↑	★★	★★	★★
BlueChoice[m]	69%	71%	72%	↑	★★	★★	★★
CIGNA[m]	67%	69%	70%	↑	★	★★	★
Coventry[m]	72%	72%	73%	⇔	★★★	★★★	★★
Kaiser Permanente[m]	65%	65%	69%	↑	★	★	★
M.D. IPA	72%	72%	79%	↑	★★	★★	★★★
OCI	72%	72%	73%	⇔	★★	★★	★★

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [m]This plan used the administrative method to calculate this rate.

Table 53

Well-Child Visits for Infants and Children (Composite), Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**70%**	**71%**	**72%**	**2%**			
Aetna[m]	63%	66%	67%	↑	★	★	★
BlueChoice[m]	70%	73%	73%	↑	★★	★★★	★★★
CIGNA[m]	72%	74%	75%	↑	★★★	★★★	★★★★
Coventry[m]	76%	77%	77%	⇔	★★★	★★★	★★★★
Kaiser Permanente[m]	63%	63%	66%	↑	★	★	★
M.D. IPA	73%	73%	77%	↑	★★★	★★	★★★
OCI	72%	71%	72%	⇔	★★★	★★	★★

Table 54

Adolescent Well-Care Visits, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**37%**	**38%**	**39%**	**2%**			
Aetna[m]	36%	38%	39%	↑	★★	★★	★★★
BlueChoice[m]	38%	42%	42%	↑	★★★	★★★	★★★★
CIGNA[m]	35%	38%	37%	↑	★	★★	★
Coventry[m]	39%	40%	40%	⇔	★★★	★★★	★★★★
Kaiser Permanente[m]	36%	36%	37%	↑	★★	★	★
M.D. IPA[m]	38%	38%	38%	⇔	★★	★★	★
OCI[m]	36%	36%	38%	⇔	★★	★★	★

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period. Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [m]This plan used the administrative method to calculate this rate.

Table 55

Well-Child and Adolescent Visits, 2006 Results								
	Well-Child Visits in the First 15 Months		Well-Child Visits in the 3rd, 4th, 5th, 6th Years		Well-Child Visits for Infants and Children (Composite)		Adolescent Well-Care Visits	
Maryland HMO/POS Average	**72%**		**73%**		**72%**		**39%**	
Aetna	62%	★	72%	★★	67%	★	39%	★★★
BlueChoice	74%	★★★	72%	★★	73%	★★★	42%	★★★★
CIGNA	80%	★★★	70%	★	75%	★★★★	37%	★
Coventry	81%	★★★	73%	★★	77%	★★★★	40%	★★★★
Kaiser Permanente	63%	★	69%	★	66%	★	37%	★
M.D. IPA	76%	★★★	79%	★★★	77%	★★★	38%	★
OCI	71%	★	73%	★★	72%	★★	38%	★

Legend

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.

★★ = Plan performed equivalent to the Maryland HMO/POS average.

★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

PRENATAL AND POSTPARTUM CARE

Background

Prenatal Care

There are over 4 million births in the United States each year (CDC, 2006). Very-low-birth-weight babies—those who weigh less than 3 pounds, 5 ounces—face a higher risk of serious, life-threatening problems. The incidence of low-birth-weight infants rose from 7.8% in 2002 to 7.9% in 2003 (CDC, 2005).

> *In 2003, the incidence of low-birth-weight infants in Maryland was 9.1%, a rate higher than the national average.*

Pregnant women should be seen by a qualified medical practitioner, obstetrician, family practitioner, or nurse midwife on a regular basis during pregnancy. Health plans that provide timely, thorough, and effective prenatal care can help reduce a woman's likelihood of having complications during pregnancy and poor health outcomes for the baby, such as low birth weight or infant mortality. Mothers who receive no prenatal care have an infant mortality rate over six times that of mothers whose prenatal care is initiated in the first trimester of pregnancy (Mathews and MacDorman, 2006). From 2003–2005, infant mortality decreased from a rate of 6.9 deaths per 1,000 live births to 6.6 deaths per 1,000 live births (National Vital Statistics Reports, 2005).

Racial and ethnic disparities exist in infant mortality rates, with that of non-Hispanic Blacks significantly and consistently higher than that of other racial or ethnic groups (ChildStats.gov, 2005). Between 1995 and 2002, the United States infant mortality rate (per 1,000 live births) was 7.1, while that of Blacks was 13.9, compared to 5.9 for non-Hispanic Whites.

> *The infant mortality rate in Maryland between 1995 and 2002 was 8.3, with 13.9 for non-Hispanic Blacks and 5.5 for non-Hispanic Whites (CDC, 2005).*

Some factors suggested to contribute to this disparity include racial differences in economic status, prevalence of specific risk factors, and access to prenatal care. Healy et al. (2006) found that even among women who had early access to prenatal care, racial disparities in perinatal mortality still occurred, with the rate for black women higher than other races (Obstetrics and Gynecology, 2006). More research is being conducted to investigate the cause of this persistent disparity and ways to close the gap.

Postpartum Care

New mothers often go through a period of physical, emotional, and social change while caring for a new baby. In recent years, postpartum depression has become a growing concern. More than 50% of the mothers surveyed in 2000 reported having low to moderate depression following the birth of their child (CDC, 2004). Postpartum depression can affect marital relationships, mother-infant bonding, and infant behavior.

The American College of Obstetricians and Gynecologists recommends that women see their health care provider at least once soon after giving birth so that they can be evaluated and receive any necessary assistance.

Measure Definition

The *Prenatal and Postpartum Care* measure includes two rates based on the population of commercially-insured women who delivered a live baby between November 6, 2004, and November 5, 2005, and who were continuously enrolled at least 43 days prior to delivery–56 days after delivery. For this population, the measure calculates the following.

Prenatal Care (Timeliness of Prenatal Care)

The percentage of women who received a prenatal care visit in the first trimester or within 42 days of enrollment in the health plan.

Postpartum Care

The percentage of women who had a postpartum visit on or between 21 and 56 days after delivery.

Data Collection Methodology

This measure can be collected using either the administrative or hybrid methodology; however, all Maryland plans used the hybrid methodology. This measure is eligible for rotation in HEDIS 2006.

Summary of Changes to HEDIS 2006

There were no significant changes.

Star Performer

The *Prenatal and Postpartum Care* measure was not reported in the *2006/2007 Consumer Guide;* therefore, it is not eligible for Star Performer designation.

Notes

Several factors can complicate calculating *Prenatal and Postpartum Care* results. When interpreting results, readers should consider the following.

- Demographic, socioeconomic, and cultural factors affect the likelihood of women seeking early prenatal care. Demographic and economic profiles of members may be very different across health plans.
- Poor quality coding of maternity data, commonly found throughout the industry, can complicate accurate measurement by creating difficulty in identifying the true number of live births.
- The majority of HMOs use global billing practices. HMOs pay providers a fixed rate for all maternity services from prenatal to postpartum care, including delivery. This payment arrangement can make it difficult to identify the number and dates of prenatal care visits.

Results

Comparison of the 2006 prenatal and postpartum rates shows that across these Maryland plans, more women received appropriate prenatal care (93%) than postpartum care (83%). On average, 17% of women did not receive the minimum level of post-delivery care.

Prenatal Care (see Table 56)

- From 2004–2006, the Maryland HMO/POS average increased by 3 percentage points to 93%.
- Three of the seven plans showed a statistically significant rate increase, while four plans did not show any statistically significant changes.
- In 2006, rates ranged from 87%–98%, with three plans receiving above-average scores, two plans receiving average scores, and two plans receiving below-average scores.

Postpartum Care (see Table 57)

- From 2004–2006, the Maryland HMO/POS average rate increased by 2 percentage points to 83%.
- One plan showed a statistically significant increase in rate, while six plans had no statistically significant changes in their rates.
- In 2006, rates ranged from 78%–88%, with two plans receiving above-average scores, four plans receiving average scores, and one plan receiving a below-average score.

Table 56

Prenatal and Postpartum Care, Prenatal Care, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**90%**	**92%**	**93%**	**3%**			
Aetna	89%	94%	95%	⇑	★★	★★	★★★
BlueChoice	94%	95%	96%	⇔	★★★	★★★	★★★
CIGNA	95%	96%	98%	⇑	★★★	★★★	★★★
Coventry[r]	84%	92%	92%	⇑	★	★★	★★
Kaiser Permanente[r]	92%	94%	94%	⇔	★★	★★	★★
M.D. IPA[r]	86%	88%	88%	⇔	★	★	★
OCI[r]	88%	87%	87%	⇔	★★	★	★

Table 57

Prenatal and Postpartum Care, Postpartum Care, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**81%**	**83%**	**83%**	**2%**			
Aetna[r]	81%	82%	82%	⇔	★★	★★	★★
BlueChoice[r]	83%	82%	82%	⇔	★★	★★	★★
CIGNA	86%	87%	88%	⇔	★★★	★★★	★★★
Coventry[r]	74%	82%	82%	⇑	★	★★	★★
Kaiser Permanente[r]	84%	87%	87%	⇔	★★	★★★	★★★
M.D. IPA[r]	80%	80%	80%	⇔	★★	★★	★★
OCI[r]	76%	78%	78%	⇔	★	★	★

Legend

Change 2004–2006

- ⇑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2006 and this plan elected to resubmit 2005 data in 2006.

SATISFACTION WITH THE EXPERIENCE OF CARE

SATISFACTION WITH THE EXPERIENCE OF CARE

Overview

This section presents selected results from the CAHPS 3.0H survey. Responses represent the opinions of HMO/POS members who composed the samples drawn from the seven plans. Kaiser POS enrollees were not included in either the survey or the audit; responses for this plan represent HMO enrollees only. For consumers making enrollment decisions, knowledge of members' level of satisfaction with a health plan provides valuable information. Member surveys systematically gather the type of information that gives consumers more depth of experience than does anecdotal evidence from family, friends, and colleagues. The results allow prospective members to assess how well current members believe their plans meet their needs.

MHCC contracted with The Myers Group to conduct the CAHPS 3.0H survey. As an NCQA-Certified survey vendor, The Myers Group administered the survey according to protocols established by NCQA. A random sample of 1,100 members of each health plan was contacted for participation in the mail survey, with phone follow-up for nonrespondents. The survey samples consisted of current health plan members, age 18 years and older, who were enrolled in the health plan throughout 2005. Survey data collection began in February 2006 and ended in April 2006.

Results presented here are based either on a single survey question or on a composite of several questions. Composite measures group several questions that rate similar aspects of health care or health plan services and have the same response options (for example, questions forming a composite measure would all have *Never/Sometimes/Usually/Always* as response choices).

Measures in Domain

- Rating of Health Plan
- Recommending Plan to Friends/Family
- Few Consumer Complaints
- Health Plan Customer Service
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Rating of Health Care

Survey data are not included in the independent audit of the HEDIS measures; however, the audit process does ensure that the population files sent to the survey vendor are not significantly biased and that they meet the technical specifications established by NCQA. These files were used by the survey vendor to draw the random survey samples representing the members of each health plan.

Overall CAHPS 3.0H Survey Results

In general, while CAHPS satisfaction results have shown some improvement, they are substantially less than the increases in HEDIS clinical rates from 2004–2006. This may be due, in part, to the ability of plans to improve HEDIS rates by increasing data completeness and improving rate calculation processes. By comparison, the survey questions and methodology are less prone to data quality/completeness issues; and therefore, rate changes are unlikely to be a result of such data issues.

Aggregate performance from 2004–2006 shows that five of the eight CAHPS measures experienced increases. Increases ranged from 2–7 percentage points, with the highest increase in the *Recommending Plan to Friends/Family* measure.

Table 58 provides a summary of the 2006 rates for all eight CAHPS measures reported here.

Table 58

Satisfaction with the Experience of Care, 2006 Results								
	Rating of Health Plan[a]	Recommending Plan to Friends/Family[b]	Few Consumer Complaints[c]	Health Plan Customer Service[d]	Getting Needed Care[d]	Getting Care Quickly[e]	How Well Doctors Communicate[e]	Rating of Health Care[f]
Maryland HMO/POS Average	38%	40%	85%	70%	76%	41%	59%	47%
Aetna	★★	★★	★★	★★	★★	★★	★★	★★
BlueChoice	★★★	★★	★★	★★	★★	★★	★★	★★★
CIGNA	★	★	★★	★	★★	★★	★★	★★
Coventry	★★	★★	★	★★	★★	★★★★	★★	★★
Kaiser Permanente	★★	★★	★★★	★★	★	★	★	★
M.D. IPA	★★	★★	★★	★★★★	★★	★★	★	★★
OCI	★★	★★	★★	★★	★★★	★★	★★	★★

Legend

Relative Rates

★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).

★★★ = Plan performed significantly better than the Maryland HMO/POS average.

★★ = Plan performed equivalent to the Maryland HMO/POS average.

★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

a. Results based on the percentage of members surveyed who gave their health plan a rating of **9 or 10** on a scale of 0–10, with 10 being the "**best health plan possible.**"

b. Results based on the percentage of members surveyed who responded **"Definitely yes"** when asked if they would recommend their health plan to friends or family.

c. Results based on the percentage of members surveyed who said they **"Did not report"** a complaint or problem with their health plan.

d. Results based on the percentage of members surveyed who responded **"Not a problem"** to several related questions.

e. Results based on the percentage of members surveyed who responded **"Always"** to several related questions.

f. Results based on the percentage of members surveyed who gave the health care they received a rating of **9 or 10** on a scale of 0–10, with 10 being the **"Best health care possible."**

RATING OF HEALTH PLAN

Measure Definition

The *Rating of Health Plan* measure asked the following question.

"Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"

Results (*see Tables 59-60*)

Rate comparisons are based on the percentage of surveyed members who gave their health plan a rating of **9 or 10** on a scale of 0–10, with 10 being the **"best health plan possible."**

- From 2004–2006, the Maryland HMO/POS average increased 4 percentage points to 38%. This means that, on average, one-third of respondents rated their plan a 9 or 10.
- In 2006, rates ranged from 31%–43%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.
- One plan had a significant increase in its rate, while the remaining plans had no significant change.

Table 59

Rating of Health Plan, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**34%**	**36%**	**38%**	**4%**			
Aetna	30%	30%	36%	⇔	★★	★	★★
BlueChoice	30%	35%	43%	🡅	★	★★	★★★
CIGNA	30%	32%	31%	⇔	★★	★	★
Coventry	37%	38%	39%	⇔	★★	★★	★★
Kaiser Permanente	38%	40%	37%	⇔	★★	★★	★★
*M.D. IPA	40%	41%	39%	⇔	★★★	★★★	★★
OCI	36%	39%	41%	⇔	★★	★★	★★

Table 60

Rating of Health Plan, 2006 Results			
	Rating 0-6	**Rating 7-8**	**Rating 9-10**
Maryland HMO/POS Average	**21%**	**41%**	**38%**
Aetna	22%	42%	36%
BlueChoice	20%	37%	43%
CIGNA	24%	45%	31%
Coventry	25%	36%	39%
Kaiser Permanente	22%	41%	37%
M.D. IPA	18%	43%	39%
OCI	19%	40%	41%

Legend

Change 2004–2006

- 🡅 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡇 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.

RECOMMENDING PLAN TO FRIENDS/FAMILY

Measure Definition

The *Recommending Plan to Friends/Family* measure asked the following question.

"Would you recommend your health plan to friends or family?"

Results (*see Tables 61-62*)

Comparisons of rates are based on the percentage of surveyed members who responded **"Definitely yes"** when asked if they would recommend their health plan to friends or family.

- From 2004–2006, the Maryland HMO/POS average increased 7 percentage points to 40%.
- On average, 40% of respondents said they "definitely" would recommend their plan, while 47% said they "probably" would recommend their plan.
- The percentage of members who said that they would "definitely" recommend their plan increased significantly for two plans, while the other plans had no significant change.
- In 2006, rates ranged from 31%–43%, with six plans receiving average scores and one plan receiving a below-average score.

Table 61

Recommending Plan to Friends/Family, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**33%**	**38%**	**40%**	**7%**			
Aetna	33%	33%	39%	⇔	★★	★	★★
BlueChoice	28%	39%	43%	🡅	★	★★	★★
CIGNA	25%	28%	31%	⇔	★	★	★
Coventry	35%	38%	38%	⇔	★★	★★	★★
Kaiser Permanente	40%	47%	42%	⇔	★★★	★★★	★★
M.D. IPA	39%	46%	43%	⇔	★★★	★★★	★★
OCI	33%	37%	42%	🡅	★★	★★	★★

Table 62

Recommending Plan to Friends/Family, 2006 Results				
	Definitely Yes	**Probably Yes**	**Probably No**	**Definitely No**
Maryland HMO/POS Average	**40%**	**47%**	**9%**	**4%**
Aetna	39%	48%	9%	4%
BlueChoice	43%	48%	7%	2%
CIGNA	31%	52%	10%	7%
Coventry	38%	44%	12%	6%
Kaiser Permanente	42%	44%	10%	4%
M.D. IPA	43%	47%	8%	2%
OCI	42%	45%	9%	4%

Legend

Change 2004–2006

- 🡅 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡇 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.

FEW CONSUMER COMPLAINTS

Measure Definition

The *Few Consumer Complaints* measure asked the following question.

"In the last 12 months, have you called or written your health plan with a complaint or problem?"

Results (*see Tables 63-64*)

Rate comparisons are based on the percentage of surveyed members who responded, **"No, did not call or write my health plan with a complaint."** Higher rates mean that fewer members complained.

- From 2004–2006, the Maryland HMO/POS average decreased 1 percentage point to 85%. On average, 15% of respondents said they had complained about their plan during 2005.
- Only one plan had a decrease in the percentage of members who said that they called or wrote their health plan (fewer complaints).
- In 2006, rates ranged from 82%–89%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.

Table 63

Few Consumer Complaints, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**86%**	**86%**	**85%**	**-1%**			
Aetna	86%	88%	83%	⇔	★★	★★	★★
BlueChoice	82%	86%	86%	⇔	★	★★	★★
CIGNA	79%	84%	85%	⇑	★	★★	★★
Coventry	86%	87%	82%	⇔	★★	★★	★
Kaiser Permanente	91%	87%	89%	⇔	★★★	★★	★★★
M.D. IPA	86%	84%	86%	⇔	★★	★★	★★
OCI	89%	88%	86%	⇔	★★★	★★	★★

Table 64

Few Consumer Complaints, 2006 Results		
	Yes, Did Complain	**No, Did Not Complain**
Maryland HMO/POS Average	**15%**	**85%**
Aetna	17%	83%
BlueChoice	14%	86%
CIGNA	15%	85%
Coventry	18%	82%
Kaiser Permanente	11%	89%
M.D. IPA	14%	86%
OCI	14%	86%

Legend

Change 2004–2006

- ⇑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.

HEALTH PLAN CUSTOMER SERVICE

Measure Definition

The *Health Plan Customer Service* measure is a composite of the following survey questions.

- *"In the last 12 months, how much of a problem, if any, was it to find or understand information in the written materials or Internet?"*

  (Only respondents who looked for information on the Internet or in written materials from the health plan in the last 12 months were asked this question.)

- *"In the last 12 months, how much of a problem, if any, was it to get help you needed when you called your health plan's customer service?"*

  (Only respondents who called their health plan's customer service department for information or help in the last 12 months about getting care for themselves were asked this question.)

- *"In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?"*

  (Respondents who had no experience with paperwork for their health plan in the last 12 months were considered to <u>have not had</u> a problem with paperwork).

Notes

Respondents who had no experience with paperwork automatically scored **"Not a problem"** to the question, "In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?"

Results (*see Tables 65-66)*

Rate comparisons are based on the percentage of members in the survey who responded **"Not a problem"** to the preceding questions.

- From 2004–2006, the Maryland HMO/POS average remained at 70%.
- One plan showed a statistically significant increase in its rate for this measure, while the other plans had no significant change.
- In 2006, rates ranged from 65%–77%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.
- One plan received a Star Performer designation for this measure.

Table 65

Health Plan Customer Service, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**70%**	**73%**	**70%**	**0%**			
Aetna	69%	73%	70%	⇔	★★	★★	★★
BlueChoice	61%	69%	68%	🡅	★	★	★★
CIGNA	62%	70%	65%	⇔	★	★★	★
Coventry	70%	71%	69%	⇔	★★	★★	★★
Kaiser Permanente	75%	72%	70%	⇔	★★★	★★	★★
M.D. IPA	77%	79%	77%	⇔	★★★	★★★	★★★★
OCI	73%	77%	71%	⇔	★★	★★	★★

Table 66

Health Plan Customer Service, 2006 Results			
	Big Problem	**Small Problem**	**Not a Problem**
Maryland HMO/POS Average	**9%**	**21%**	**70%**
Aetna	9%	21%	70%
BlueChoice	13%	20%	68%
CIGNA	10%	24%	65%
Coventry	11%	20%	69%
Kaiser Permanente	8%	22%	70%
M.D. IPA	6%	18%	77%
OCI	6%	22%	71%

Legend

Change 2004–2006

- 🡅 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡇 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.

GETTING NEEDED CARE

Measure Definition

The *Getting Needed Care* measure is a composite of the following survey questions.

- *"Since you joined your health plan, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?"*
  (Only respondents who got a new personal doctor/nurse when they joined the health plan were asked this question.)
- *"In the last 12 months, how much of a problem, if any, was it to see a specialist that you needed to see?"*
  (Only respondents who thought they needed to see a specialist in the last 12 months were asked this question.)
- *"In the last 12 months, how much of a problem, if any, was it to get the care, tests, or treatment you or a doctor believed necessary?"*
  (Only respondents who thought they needed care, tests, or treatment in the last 12 months for themselves were asked this question.)
- *"In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?"*
  (Only respondents who needed approval from their health plan for care, tests, or treatment in the last 12 months for themselves were asked this question.)

Notes

Respondents who did not require approval for care, tests, or treatment were automatically scored **"Not a problem"** for the question, "In the last 12 months, did you need approval from your health plan for any care, test, or treatment?" This composite measure is in the *2006/2007 Consumer Guide*; therefore, it is eligible for Star Performer designation.

Results *(see Tables 67-68)*

Rate comparisons are based on the percentage of members surveyed who responded **"Not a problem"** to the preceding questions.

- From 2004–2006, the Maryland HMO/POS average increased 2 percentage points to 76%.
- In 2006, rates ranged from 71%–79%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.

Table 67

Getting Needed Care, Trending							
	Comaparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**74%**	**77%**	**76%**	**2%**			
Aetna	70%	73%	74%	⇔	★	★	★★
BlueChoice	72%	78%	77%	⇔	★★	★★	★★
CIGNA	67%	75%	77%	⇑	★	★★	★★
*Coventry	82%	86%	79%	⇔	★★★	★★★	★★
Kaiser Permanente	73%	77%	71%	⇔	★★	★★	★
M.D. IPA	77%	76%	75%	⇔	★★★	★★	★★
OCI	74%	76%	79%	⇔	★★	★★	★★★

Table 68

Getting Needed Care, 2006 Results			
	Big Problem	**Small Problem**	**Not a Problem**
Maryland HMO/POS Average	**8%**	**16%**	**76%**
Aetna	9%	17%	74%
BlueChoice	7%	15%	77%
CIGNA	8%	15%	77%
Coventry	7%	14%	79%
Kaiser Permanente	9%	20%	71%
M.D. IPA	9%	16%	75%
OCI	6%	14%	79%

Legend

Change 2004–2006

⇑ Plan rate increased significantly from 2004 to 2006.
⇔ Plan rate *did not* change significantly from 2004 to 2006.
⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.

GETTING CARE QUICKLY

Measure Definition

The *Getting Care Quickly* measure is a composite of the following survey questions.

- *"In the last 12 months, when you called during regular office hours, how often did you get the help or advice you needed?"*

  (Only respondents who called a doctor's office during regular office hours to get help or advice for themselves in the last 12 months were asked this question.)

- *"In the last 12 months, when you needed care right away for an illness, injury, or condition, how often did you get care as soon as you wanted?"*
  (Only respondents who thought they needed care right away in the last 12 months were asked this question.)

- *"In the last 12 months, not counting the times you needed health care right away, how often did you get an appointment for health care as soon as you wanted?"*

  (Only respondents who made an appointment for health care they did not need right away in the last 12 months were asked this question.)

- *"In the last 12 months, how often were you taken to the exam room within 15 minutes of your appointment?"*

  (Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked this question.)

Notes

This composite measure is in the *2006/2007 Consumer Guide*; therefore, it is eligible for Star Performer designation.

Results *(see Tables 69-70)*

Rate comparisons are based on the percentage of surveyed members surveyed who responded **"Always"** to the preceding questions.

- From 2004–2006, the Maryland HMO/POS average decreased 1 percentage point to 41%.
- In 2006, rates ranged from 37%–48%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.
- No plan saw a significant change in its 2006 rate, although one plan received the Star Performer designation for this measure.

Table 69

Getting Care Quickly, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**42%**	**44%**	**41%**	**-1%**			
Aetna	42%	42%	40%	⇔	★★	★★	★★
BlueChoice	40%	43%	44%	⇔	★★	★★	★★
CIGNA	37%	43%	41%	⇔	★	★★	★★
Coventry	47%	49%	48%	⇔	★★★	★★★	★★★★
Kaiser Permanente	41%	43%	37%	⇔	★★	★★	★
M.D. IPA	41%	42%	38%	⇔	★★	★★	★★
OCI	47%	44%	41%	⇔	★★★	★★	★★

Table 70

Getting Care Quickly, 2006 Results			
	Sometimes/ Never	**Usually**	**Always**
Maryland HMO/POS Average	**26%**	**33%**	**41%**
Aetna	27%	34%	40%
BlueChoice	23%	32%	44%
CIGNA	27%	32%	41%
Coventry	19%	33%	48%
Kaiser Permanente	30%	32%	37%
M.D. IPA	28%	33%	38%
OCI	27%	31%	41%

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.

HOW WELL DOCTORS COMMUNICATE

Measure Definition

The *How Well Doctors Communicate* measure is a composite of several questions. Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked the following survey questions.

- *"In the last 12 months, how often did doctors or other health providers listen carefully to you?"*
- *"In the last 12 months, how often did doctors or other health providers explain things in a way you could understand?"*
- *"In the last 12 months, how often did doctors or other health providers show respect for what you had to say?"*
- *"In the last 12 months, how often did doctors or other health providers spend enough time with you?"*

Results *(see Tables 71-72)*

Comparisons of rates are based on the percentage of surveyed members who responded **"Always"** to the preceding questions.

- From 2004–2006, the Maryland average increased 3 percentage points to 59%.
- Only one plan showed a significant increase in the percentage of members who said that their doctor always communicated well, while the remaining plans had no significant change.
- In 2006, rates ranged from 55%–62%, with five plans receiving average scores and two plans receiving below-average scores.

Table 71

How Well Doctors Communicate, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**56%**	**60%**	**59%**	**3%**			
Aetna	58%	57%	61%	⇔	★★	★★	★★
BlueChoice	56%	60%	62%	⇔	★★	★★	★★
CIGNA	50%	62%	59%	⇑	★	★★	★★
Coventry	59%	64%	61%	⇔	★★	★★★	★★
Kaiser Permanente	52%	55%	55%	⇔	★★	★	★
M.D. IPA	56%	55%	55%	⇔	★★	★	★
OCI	57%	64%	60%	⇔	★★	★★★	★★

Table 72

How Well Doctors Communicate, 2006 Results			
	Sometimes/ Never	**Usually**	**Always**
Maryland HMO/POS Average	**10%**	**31%**	**59%**
Aetna	7%	31%	61%
BlueChoice	9%	29%	62%
CIGNA	10%	31%	59%
Coventry	7%	31%	61%
Kaiser Permanente	13%	31%	55%
M.D. IPA	12%	32%	55%
OCI	9%	30%	60%

Legend

Change 2004–2006

- ⇑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.

RATING OF HEALTH CARE

Measure Definition

The *Rating of Health Care* measure asked the following question.

"Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?"

Results *(see Tables 73-74)*

Rate comparisons are based on the percentage of members surveyed who gave their health care a rating of 9 or 10 on a scale of 0–10, with 10 being the **"Best health care possible."**

- From 2004–2006, the Maryland HMO/POS average increased by 2 percentage points to 47%.
- In 2006, rates ranged from 41%–53%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.
- No plan experienced a significant increase in its rate.

Table 73

Rating of Health Care, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**45%**	**45%**	**47%**	**2%**			
Aetna	45%	41%	47%	⇔	★★	★★	★★
BlueChoice	46%	48%	53%	⇔	★★	★★	★★★
CIGNA	42%	43%	44%	⇔	★★	★★	★★
Coventry	50%	51%	51%	⇔	★★★	★★★	★★
Kaiser Permanente	42%	44%	41%	⇔	★★	★★	★
M.D. IPA	46%	44%	45%	⇔	★★	★★	★★
OCI	46%	45%	49%	⇔	★★	★★	★★

Table 74

Rating of Health Care, 2006 Results			
	Rating 0-6	**Rating 7-8**	**Rating 9-10**
Maryland HMO/POS Average	**14%**	**39%**	**47%**
Aetna	15%	38%	47%
BlueChoice	11%	35%	53%
CIGNA	14%	42%	44%
Coventry	10%	39%	51%
Kaiser Permanente	18%	41%	41%
M.D. IPA	16%	39%	45%
OCI	14%	37%	49%

Legend

Change 2004–2006

- ↑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ↓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.

USE OF SERVICES

USE OF SERVICES

Overview

This section presents results for measures in the 2006 HEDIS *Use of Services* domain that MHCC required Maryland HMOs to report in 2006. Descriptive indicators and rates related to facility utilization include information on inpatient discharges and average length of stay (ALOS), and ambulatory care. Monitoring utilization is essential for any MCO, and the *Use of Services* rates included in this section can be valuable for analytical purposes.

The *Use of Services* measures are collected as a way of identifying variation in utilization levels. Although there are no utilization measure standards, plans can use these results to initially identify outlier rates. Outlier rates indicate that something unusual is occurring with the plan, its providers, or its members, or that the plan's data collection system is flawed. The concept behind collecting these data is that, once identified, HMOs can target areas for further study or improvement.

Results for measures in this domain are affected by many member characteristics that can vary greatly among health plans, including age, gender, current medical condition, socioeconomic status, and race. Rates that are three standard deviations from the mean are not included. For *Frequency of Use* measures, rates of utilization are often expressed as rates of service used per 1,000 member months, or they may be converted to rates of service used per year. Unlike *Effectiveness of Care* and *Access/Availability of Care* measures, continuous enrollment criteria do not factor into most of these rate calculations. The number of member months is the sum of the number of months each member is enrolled in the plan each year. For plans with stable memberships, the reported number of member years is close to the number of members enrolled at any point in time during the year. This comparison may not apply to plans with growing or declining enrollment. ***For these measures, rates are not correlated with performance.***

Measures in Domain

- Inpatient Utilization—General Hospital/Acute Care
- Inpatient Utilization—Nonacute Care
- Ambulatory Care
- Discharges and Average Length of Stay—Maternity Care
- Births and Average Length of Stay, Newborn
- Outpatient Drug Utilization
- Frequency of Selected Procedures

Factors Affecting Interpretation of Results

Several factors complicate interpreting the *Use of Services* measures and can lead to misleading results. Readers should consider the following.

- Utilization is significantly influenced by characteristics of the member population. HEDIS rates are not risk adjusted, so variation in results between plans may be affected by real differences in member health, race, education, and socioeconomic status. These differences may be most obvious in rates of utilization for various procedures.
- Standards or accepted targets for these rates do not exist. High rates *could* indicate overutilization, while low rates *could* indicate underutilization.
- Many of these measures rely on data for the entire population rather than a sample; therefore, results are more likely to be affected by data completeness issues.
- Health plan utilization departments do not always measure utilization using the same method as the HEDIS specifications, so health plans do not have comparable internal rates to determine reasonableness of the results.

As a result of the factors listed above, relative rates (i.e., above/below average scores) *are not* presented for rates of procedures. Inter-plan comparisons are not appropriate. In addition, given the large number of these measures, only 2006 rates are presented. Rates for previous years can be found in the *Comprehensive Report* for that year.

INPATIENT UTILIZATION—GENERAL HOSPITAL/ACUTE CARE

Measure Definition

The *Inpatient Utilization—General Hospital Care* measure reports the rate of utilization of general hospitals for treatment of acute conditions and ALOS. Three separate rates are reported: all patients (**Total**), medical patients (**Medicine**), and surgical patients (**Surgery**). Information on maternity utilization is also presented as a subset measurement, *Discharges and Average Length of Stay—Maternity Care,* in this section.

Notes

When interpreting this information, it is important to remember that these results are not risk adjusted for demographic characteristics or severity of illness. Neither availability nor use of outpatient alternatives is considered.

Results *(see Table 75)*

- The average number of discharges decreased slightly per 1,000 members across all categories compared to 2005 rates. *Total* decreased from 60.2 to 59.5, *Medical* decreased from 25.6 to 25.4, and *Surgical* decreased from 20.2 to 19.7.
- Rates of *Medical* discharges ranged from 22.0/1,000 members to 28.6/1,000 members, and rates of *Surgical* discharges ranged from 14.7/1,000 members to 22.9/1,000 members.
- ALOS ranged from 2.7–3.8 days for *Medical* and 3.8–5.1 days for *Surgical*.

Table 75

Inpatient Utilization--General Hospital/Acute Care, 2006 Results						
	Discharges/1,000 Members			Average Length of Stay (Days)		
	Total	Medical	Surgical	Total	Medical	Surgical
Maryland HMO/POS Average	**59.5**	**25.4**	**19.7**	**3.5**	**3.2**	**4.4**
Aetna	60.1	27.0	18.8	3.7	3.3	4.4
BlueChoice	60.1	22.0	22.6	3.4	3.1	4.0
CIGNA	54.3	22.8	18.3	3.9	3.8	4.8
Coventry	66.1	28.6	18.0	3.2▼	2.9▼	3.8
Kaiser Permanente	50.4	23.3	14.7	3.9	3.8	5.1▲
M.D. IPA	61.0	26.6	22.9	3.5	2.8▼	4.5
OCI	64.4	27.5	22.6	3.2▼	2.7▼	4.2

"Total" discharges and ALOS include maternity care.

Legend

▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

INPATIENT UTILIZATION—NONACUTE CARE

Measure Definition

The *Inpatient Utilization—Nonacute Care* measure reports the rate of utilization and ALOS for inpatient, nonacute care. Inpatient, nonacute care includes inpatient care received in the following facilities: hospice, nursing home, rehabilitation, skilled nursing facilities, transitional, and respite care. Mental health and chemical dependency facilities are excluded. Rates are per 1,000 members.

Notes

When interpreting this information, it is important to remember that results are not risk-adjusted for demographic characteristics and use of outpatient alternatives. Data completeness can be a significant issue for plans when generating this measure, and it could lead to underreporting.

Results *(see Table 76)*

- In 2006, Maryland plans reported 1.9 discharges/1,000 members, on average, with rates for discharges ranging from 1.0/1,000 members to 4.2/1,000 members.
- ALOS decreased very slightly in 2006 from the 2005 reported rate, shifting from 13.7 days/ 1,000 members to 13.6 days/1,000 members. Rates ranged from 12.6–14.5 days.

Table 76

Inpatient Utilization--Non-Acute Care, 2006 Results		
	Discharges/1,000 Members	**ALOS (Days)**
Maryland HMO/POS Average	**1.9**	**13.6**
Aetna	1.4	13.5
BlueChoice	1.4	13.5
CIGNA	1.7	14.3
Coventry	1.0	14.5
Kaiser Permanente	4.2▲	13.1
M.D. IPA	2.0	13.7
OCI	1.7	12.6

Legend

▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

AMBULATORY CARE

Measure Definition

The *Ambulatory Care* measure reports member use of ambulatory services, including outpatient visits, emergency department (ED) visits, and ambulatory surgeries/procedures. Rates are per 1,000 members.

Notes

An outpatient visit is a face-to-face encounter between the practitioner and patient for routine care. It provides a reasonable proxy for professional ambulatory encounters.

ED visits are sometimes used as a substitute for ambulatory clinic encounters. Although patient behavior is a factor in the decision to use an ED rather than a clinic or physician's office, the decision also may result from insufficient access to primary care. A health plan that provides adequate preventive services and effectively manages ambulatory treatment of patients by offering alternative treatment benefits, such as urgent care coverage, should be able to keep the number of ED visits relatively low. Ambulatory surgeries include procedures performed at a hospital outpatient facility or at a freestanding surgery center; office-based surgeries/procedures are excluded from this measure.

The increasing use of outpatient surgery as an alternative to inpatient surgery can create data interpretation issues. For hospital organizations with semi-attached ambulatory surgery centers, the distinction between service venues may be confused during data processing.

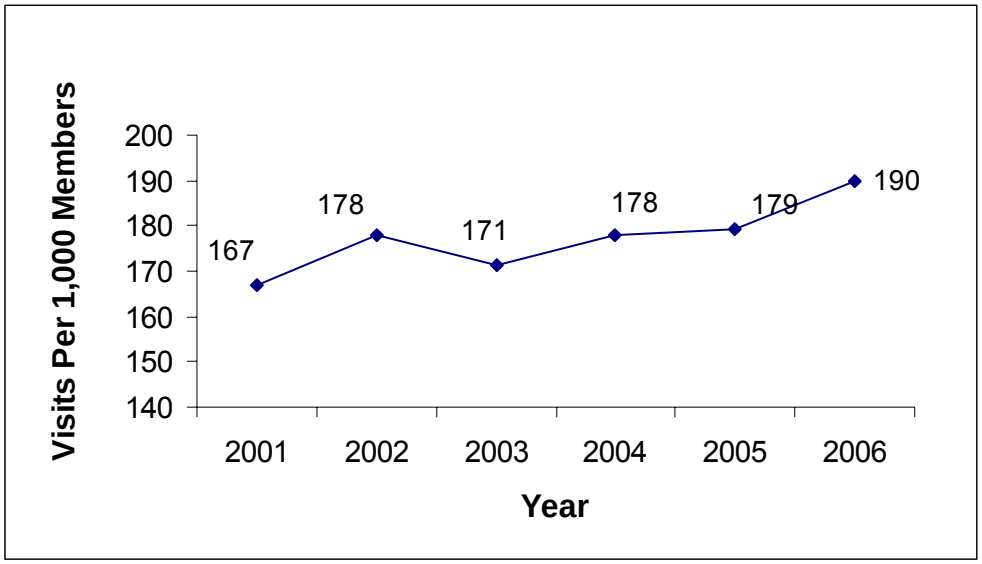
Results *(see Tables 77-78)*

- The Maryland HMO/POS average number of outpatient visits increased from 3,749 in 2005 to 3,865 in 2006. Rates ranged from 3,465 visits/1,000 members to 4,431 visits/ 1,000 members.
- The Maryland HMO/POS average number of ED visits was 190/1,000 members and ranged from 132 visits/1,000members to 221 visits/1,000 members. Compared to the 2005 average rate of 179 visits/1,000 members. ED visits for this reporting period increased an average of 11 visits/1,000 members.
- Maryland HMO/POS average rates for ambulatory surgeries/procedures increased from the 2004 rate of 106 to 108 in 2005. Rates ranged from 60 procedures/1,000 members to 155 procedures/1,000 members.

Table 77

Ambulatory Care, 2006 Results			
	Visits/1,000 Members		
	Outpatient Visits	ED Visits	Ambulatory Surgery/Procedure
Maryland HMO/POS Average	**3,865**	**190**	**108**
Aetna	3,574	193	104
BlueChoice	3,659	221	60▼
CIGNA	3,806	191	97
Coventry	4,251	186	155▲
Kaiser Permanente	4431▲	132▼	62▼
M.D. IPA	3,869	195	143
OCI	3,465	212	134

Table 78: Emergency Department, Trending



Legend

▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

DISCHARGES AND AVERAGE LENGTH OF STAY—MATERNITY CARE

Measure Definition

The *Discharges and Average Length of Stay—Maternity Care* measure reports maternity-related care based upon the **rate of live births** during 2005 and includes the hospital ALOS related to those births. Delivery information is broken down into vaginal and cesarean section (C-section) categories. Rates are per 1,000 *female* members age 10 years and older.

Notes

The implementation of the Newborns' and Mothers' Health Protection Act of 1996 mandates a minimum length of obstetric stays: two days for vaginal deliveries and four days for C-sections; however, a mother may request a shorter length of stay if she decides, in consultation with her provider, that less time is needed for recovery. In cases where the mother has a shorter hospital stay than provided for under the law, coverage is given for one home visit, to occur within 24 hours after hospital discharge. This mandate does not establish a follow-up care schedule that could best detect common problems to newborns three to four days after birth.

Plans can provide high-quality care without having longer hospital stays. Safe, earlier discharges with pediatric and maternal follow-up through home-care nursing visits give new mothers an option in post-delivery care. The factor that most complicates maternity-related HEDIS measures is the identification of live births. Poor quality coding of maternity data is an industry-wide problem and is the chief culprit complicating accurate measurement of rates based on identifying live births.

Results *(see Table 79)*

- Total maternity discharge rates range from 21.3/1,000 female members to 29.5/1,000 female members.
- The average length of stay for C-section births is longer, as expected, than for vaginal births (4.0 days, compared to 2.4 days).
- The *Total* ALOS varies across plans, from 2.5–3.7 days.

Table 79

Discharges and Average Length of Stay - Maternity Care, 2006 Results						
	Discharges/1,000 Female Members			Average Length of Stay (Days)		
	Total	Vaginal	C-Section	Total	Vaginal	C-Section
Maryland HMO/POS Average	**25.5**	**16.6**	**8.9**	**2.9**	**2.4**	**4.0**
Aetna	29.4	18.5	10.8	3.7▲	2.6▲	5.4▲
BlueChoice	29.5	19.5	10.0	2.8	2.2	3.9
CIGNA	27.1	17.6	9.5	3.0	2.3	4.1
Coventry	21.3	14.4	6.9	2.5	2.2	3.2
Kaiser Permanente	21.3	13.8▼	7.5	2.8	2.2	3.8
M.D. IPA	21.9	13.9▼	8.0	3.2▲	2.7▲	4.0
OCI	28.1	18.6	9.6	2.8	2.2	3.8

Legend

▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

BIRTHS AND AVERAGE LENGTH OF STAY—NEWBORNS

Measure Definition

The *Births and Average Length of Stay—Newborns* measure summarizes utilization information about newborns discharged during 2005 and reports information for total newborns, well newborns, and complex newborns discharged per 1,000 members. Complex newborns are those whose length of stay is greater than or equal to five days, or whose length of stay is less than five days and the newborn expired, or those who were transferred to another facility and the plan is unable to track total length of stay between the two facilities. Well newborns have a length of stay of less than five days. Total newborns combines well and complex newborns.

Notes

Newborn care refers to services provided from birth to discharge to home. This measure includes newborns delivered in an inpatient setting and at birthing centers. For newborns delivered in birthing centers, one day of stay is counted. If a newborn is transferred from one hospital to another and had never gone home, the care is still newborn care. Newborn care that is rendered after a baby has been discharged is reported under the *Inpatient Utilization- General Hospital/Acute* Care measure.

Some plans do not keep separate records on well newborns that leave the hospital at the same time as their mothers. The plan must develop a methodology to estimate the number of well newborns for whom the plan does not produce separate discharge records. For example, the mother's length of stay can be used as a proxy for the well newborn's length of stay. The plan must provide documentation for the approach used.

Results (*See Table 80*)

- On average, the well newborn rate was 9.9/1,000 members, compared to a rate of 0.9/1,000 members for complex newborns.
- As expected, complex newborns had a greater average length of stay (16 days) compared to the well newborns (2.4 days).
- The total number of discharges per 1,000 members varied between 9.0 and 13.5, while the total average length of stay varied between 3.0 and 4.0 days.

Table 80

Births and Average Lengths of Stay—Newborns, 2006 Results						
	Discharges/1,000 Members			Average Length of Stay (Days)		
	Total	Well	Complex	Total	Well	Complex
Maryland HMO/POS Average	**10.8**	**9.9**	**0.9**	**3.5**	**2.4**	**16.0**
Aetna	10.0	9.1	0.9	4.0▲	2.4	19.2
BlueChoice	13.5	12.2	1.3▲	3.4	2.5▲	11.9
CIGNA	12.6	11.5	1.1	3.7	2.4	16.7
Coventry	10.1	9.3	0.8	3.4	2.1	17.3
Kaiser Permanente	10.6	9.9	0.7	3.0	2.4	11.2
M.D. IPA	9.0▼	8.3	0.7	3.5	2.4	17.8
OCI	9.9	9.1	0.7	3.5	2.3	17.9

Legend

▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

OUTPATIENT DRUG UTILIZATION

Measure Definition

The *Outpatient Drug Utilization* measure reports the number of prescriptions dispensed per member, per year (PMPY) and the average cost of prescriptions per member, per month (PMPM). Only members whose benefits include prescription drug coverage through their HMOs are included. This measure excludes drugs that members are given in the hospital and only includes prescriptions covered by their health plan. Because many employers "carve out" drug benefits from their contracts with health plans, data do not reflect a true picture of prescription drug use by all plan members.

Notes

Plans accredited by NCQA have met the standards for pharmaceutical management, which includes formulary development. Information about NCQA's pharmacy management standards is included in the *External Accreditation* section of this report.

Results

The specifications for the *Outpatient Drug Utilization* measure guide plans on the collection of data to calculate the cost of prescriptions per member per month and the average number of prescriptions per member per year. The current specifications do not adequately account for scenarios where the member cost exceeds the cost of the medication. NCQA provided clarification on the interpretation of the measure specifications during the data collection period. There was not sufficient time for plans to assess the impact of the clarification on their reported rates.

In 2006, the average commercial HMO member in Maryland received 11.0 prescriptions during the year, at a cost of $47.76 per member per month. In 2005, the rate was 10.2 prescriptions per member per year. The current reported rate reflects an average increase of 0.8 prescriptions. Additionally, the monthly cost has increased $6.52 per member, which is much higher than the $0.17 increase seen between 2004 and 2005.

FREQUENCY OF SELECTED PROCEDURES

Background

The *Frequency of Selected Procedures* measure reports utilization rates for several (mostly surgical) procedures that are performed frequently and contribute substantially to health care costs. Considerable variation exists in how often the procedures are performed. Rates for these measures are likely to be strongly influenced by how a health plan manages care, as well as by the demographic characteristics of the plan's members. Data were collected using the administrative method.

Measure Definition

Utilization rates for the following procedures are included as part of the *Frequency of Selected Procedures* measure.

Myringotomy: Incision of the eardrum to allow insertion of ventilating tubes; a treatment for chronic ear infections.

Tonsillectomy/Tonsillectomy and Adenoidectomy: Surgical removal of the tonsils or tonsils and adenoids.

Nonobstetric Dilation and Curettage (D&C): Dilation and surgical cleansing of the surface of the uterus.

Hysterectomy: Surgical removal of the uterus.

Cholecystectomy, open: Surgical removal of the gallbladder through an abdominal incision.

Cholecystectomy, closed (laparoscopic): The surgical removal of the gallbladder with a laparoscope.

Angioplasty: Repairing or replacing damaged blood vessels using lasers or tiny inflatable balloons at the end of a catheter that is inserted into the vessels.

Cardiac Catheterization: A procedure used to diagnose the severity and extent of coronary artery disease.

Coronary Artery Bypass Graft (CABG): A surgical procedure used to treat coronary heart disease by grafting a portion of a vein from the patient to replace the portion of the damaged or blocked coronary artery.

Prostatectomy: Surgical removal of the prostate gland.

Back Surgery: spinal fusions and disc surgeries, including laminectomies with and without disc removal.

Mastectomy: Surgical removal of all or most of the breast.

Lumpectomy: Surgical removal of a small tumor from the breast.

Results *(see Tables 81-85)*

Results for these procedures are presented in the tables on the following pages. To create a standardized result across different sized plans, results appear as rates/1,000 (i.e., the number of times a procedure was performed per 1,000 plan members). This makes it possible to compare very large and very small plans to each other. In most cases, rates are displayed by age and gender because these two factors have much to do with health status and the types of health problem for which people seek care.

Rates for selected procedures included in the *Comprehensive Report* facilitate comparison and analysis by plans, providers, and other organizations. As noted in the *Overview* section at the beginning of this chapter, utilization rates are significantly influenced by the characteristics of the plan's member population and are vulnerable to data completeness issues. The rates are not risk adjusted, so variation in results between plans may not be attributed to differences in performance. Further, there is no accepted standard or target for utilization measures; therefore, relative rates are not calculated and interplan comparisons are not made here. Only 2006 rates are presented. Rates for previous years can be found in the *Comprehensive Report* for the year in question.

Table 81

Frequency of Myringotomies and Tonsillectomies, 2006 Results				
	Procedures/1,000 Members			
	MYR 0-4 years M&F	MYR 5-19 years M&F	TA 0-9 years M&F	TA 10-19 years M&F
Maryland HMO/POS Average	**41.1**	**3.5**	**7.7**	**3.4**
Aetna	41.3	3.6	6.6	3.3
BlueChoice	19.3	1.9▼	8.0	4.4
CIGNA	54.0	3.8	8.2	3.1
Coventry	67.9	6.3	11.9	3.8
Kaiser Permanente	13.6▼	1.6▼	4.2▼	1.5▼
M.D. IPA	43.8	2.8	6.7	3.4
OCI	48.1	4.7	8.2	3.9

Notes: MYR = Myringotomy
TA = Tonsillectomy or Tonsillectomy and Adenoidectomy
M&F = Male and Female

Table 82

Frequency of Dilation & Curettages and Hysterectomies, 2006 Results						
	Procedures/1,000 Female Members					
	D&C 15-44 yrs	D&C 45-64 yrs	HYS-ab 15-44 yrs	HYS-ab 45-64 yrs	HYS-vag 15-44 yrs	HYS-vag 45-64 yrs
Maryland HMO/POS Average	**4.2**	**5.7**	**3.4**	**5.5**	**1.9**	**2.4**
Aetna	4.9	6.1	3.8	6.5	2.1	2.4
BlueChoice	5.1	6.9	3.4	5.8	1.7	2.3
CIGNA	2.0	2.1	3.4	4.8	2.5	2.6
Coventry	5.9▲	10.0▲	3.5	4.6	2.3	2.4
Kaiser Permanente	0.5▼	1.1▼	2.7	4.9	0.5▼	1.0▼
M.D. IPA	5.8	7.0	3.6	5.8	1.9	3.3
OCI	5.3	6.7	3.5	6.1	2.1	2.8

Notes: D&C = Dilation & Curettage
HYS-ab = Hysterectomy—Abdominal
HYS-vag = Hysterectomy—Vaginal

Legend
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

Table 83

Frequency of Cholecystectomies, 2006 Results						
	Procedures/1,000 Members					
	Chol-o 30-64 yrs Male	Chol-o 15-44 yrs Female	Chol-o 45-64 yrs Female	Chol-c 30-64 yrs Male	Chol-c 15-44 yrs Female	Chol-c 45-64 yrs Female
Maryland HMO/POS Average	**0.3**	**0.3**	**0.5**	**1.9**	**4.0**	**5.2**
Aetna	0.3	0.3	0.5	1.9	3.7	4.5
BlueChoice	0.3	0.2	0.5	1.9	4.3	5.6
CIGNA	0.2	0.3	0.5	1.8	3.9	5.1
Coventry	0.4	0.2	0.2	2.0	5.6	7.0
Kaiser Permanente	0.4	0.2	0.4	1.1▼	2.4▼	2.8▼
M.D. IPA	0.3	0.3	0.8▲	2.0	3.6	5.5
OCI	0.3	0.3	0.5	2.3	4.7	5.7

Notes: Chol-o = Cholecystectomy—Open
Chol-c = Cholecystectomy—Closed (Laparoscopic)

Table 84

Frequency of Back Surgeries, 2006 Results				
	Procedures/1,000 Members			
	Back Surgery 20-44 yrs Male	Back Surgery 20-44 yrs Female	Back Surgery 45-64 yrs Male	Back Surgery 45-64 yrs Female
Maryland HMO/POS Average	**8.0**	**9.9**	**16.2**	**17.9**
Aetna	8.2	11.7	16.7	18.9
BlueChoice	2.8▼	2.2▼	5.2▼	5.6▼
CIGNA	8.0	11.8	18.7	21.9
Coventry	11.9	13.9	22.6	19.3
Kaiser Permanente	5.6	6.7▼	12.4	15.7
M.D. IPA	8.6	11.0	19.7	21.4
OCI	10.5	11.7	17.9	22.2

Legend
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

Table 85

Frequency of Cardiac Procedures, 2006 Results						
	Procedures/1,000 Members					
	Ang 45-64 yrs Male	Ang 45-64 yrs Female	CC 45-64 yrs Male	CC 45-64 yrs Female	CABG 45-64 yrs Male	CABG 45-64 yrs Female
Maryland HMO/POS Average	**7.6**	**2.3**	**10.9**	**7.7**	**2.6**	**0.7**
Aetna	7.5	2.5	10.2	8.1	1.7	0.8
BlueChoice	8.4	2.5	11.4	7.3	2.5	0.6
CIGNA	7.1	2.6	12.5	7.7	1.9	0.4
Coventry	8.9	2.6	12.5	10.4	5.0▲	1.4
Kaiser Permanente	3.7▼	1.4	5.2▼	3.6▼	1.7	0.5
M.D. IPA	8.2	2.1	11.9	8.5	2.4	0.7
OCI	9.2	2.4	12.8	8.2	2.8	0.6

Notes: Ang = Angioplasty
CC = Cardiac Catheterization
CABG = Coronary Artery Bypass Graft

Table 86

Frequency of Mastectomies, Lumpectomies, and Prostatectomies 2006 Results					
	Procedures/1,000 Members				
	Mastectomy		Lumpectomy		Prostatectomy
	15-44 yrs Female	45-64 yrs Female	15-44 yrs Female	45-64 yrs Female	45-64 yrs Male
Maryland HMO/POS Average	**0.3**	**1.4**	**3.8**	**7.9**	**2.6**
Aetna	0.4	1.2	3.9	8.4	2.5
BlueChoice	0.3	1.2	3.9	8.1	2.5
CIGNA	0.3	1.4	3.0	7.3	3.1
Coventry	0.3	1.9	4.1	8.1	4.0▲
Kaiser Permanente	0.2▼	1.4	2.9	7.0	1.6▼
M.D. IPA	0.3	1.4	4.4	9.0	2.4
OCI	0.4	1.1	4.6	7.7	2.4

Notes: Rates for mastectomy and lumpectomy apply to only female members in the individual age groups: ages 15-44 and 45-64 years.
Rates for prostatectomy apply to only male members in the age group 45-64 years.

Legend
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally

BEHAVIORAL HEALTHCARE

BEHAVIORAL HEALTHCARE

Overview

This section contains results of performance indicators related to behavioral healthcare. In addition to collecting behavioral health performance data using the HEDIS measurement tool, HMOs provided information on the behavioral health providers serving the same geographic area that the health plan serves.

Mental illness affects over 57 million Americans 18 years or older (JAMA, 2004), with many cases going undiagnosed because of stigma and complexity in diagnosis. Without treatment, symptoms associated with mental illness disorders can last for years, affecting quality of life, costing society, and sometimes leading to excess morbidity and mortality. Despite the high prevalence of mental illness in the United States, many people do not have access to the services they need. The National Comorbidity Survey Replication study, supported by the National Institute of Mental Health, found that less than half of people with mental illness get needed care, and that care is usually delayed and often inadequate (2005). Lack of investment in mental health care is very costly, not only in terms of direct treatment costs, but also because it can lead to lost productivity, homelessness, increased crime, delinquency, substance abuse, and unemployment, among other things. This translates into $113 billion annually in direct and indirect cost, with $105 billion due to lost productivity alone (National Mental Health Association, NMHA).

Many people lack access to mental health services because mental health insurance, when available, often provides very limited coverage, imposing limitations such as maximum number of visits, higher co-payments and deductibles, and annual and lifetime spending caps (NMHA, 2005). Thirty-four states have passed mental health parity legislation, which aims to ban these types of limitations on mental health coverage.

> *Maryland, Connecticut, and Vermont have exemplary parity laws that apply to all mental health and substance abuse disorders under private insurance plans, with no exemptions (NMHA). Maryland's Mental Health Parity Law, passed in July 1994, requires all insurance plans and HMOs (except those for small businesses and self-insured companies) to provide mental health benefits equivalent to other medical benefits (Maryland Department of Metal Hygiene).*

Managed behavioral health organizations are separate organizations that contract with health plans or employers to provide only mental health care and chemical dependency services. Health plans often contract with MBHOs for specialized services rather than provide them to members directly, though they remain legally responsible for ensuring the quality of care provided by the MBHO.

Utilization data for people who received behavioral health services via a separate contract between their employer and an MBHO or through a private arrangement are not included in the results presented here.

Measures in Domain

- Follow-Up After Hospitalization for Mental Illness: 7-day and 30-day
- Antidepressant Medication Management: Optimal Practitioner Contacts, Acute and Continuation Treatment Phases
- Mental Health Utilization: Inpatient Discharges and Average Length of Stay
- Mental Health Utilization: Percentage of Members Receiving Inpatient, Day/Night Care or Ambulatory Services
- Chemical Dependency Utilization: Inpatient Discharges and Average Length of Stay
- Identification of Alcohol and Other Drug Services
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Behavioral Healthcare Provider Network

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Background

Mental illnesses such as depression, schizophrenia, and bipolar disorder are significant causes of disability in the United States. Mental disorders can lead to suicide, one of the leading preventable causes of death. In some cases, severity of symptoms can lead to hospitalization. In 2004, there were over 51 million ambulatory visits for mental disorders (CDC, 2006). To help ensure that hospitalization benefits are sustained, patients should receive follow-up visits with a mental health practitioner shortly after hospital discharge. Contact within seven days is important to ensure that patients have the necessary supports to make the transition home and to help prevent hospital readmission during this period of high risk for relapse or decline. The number of days between hospital discharge and follow-up appointment is a significant predictor of nonadherence, independent of mental illness type and severity (Compton, Rudisch, Craw, Thompson, and Owens, 2006). An outpatient visit with a mental health practitioner within 30 days of discharge can help patients manage in the longer term; this may include medication adjustment and developing psychological and social supports. For a mental condition such as schizophrenia, psychiatric treatment nonadherence dramatically increases the risk of rehospitalization.

Studies have found that adequate case management following discharge is effective in reducing early rehospitalization in depressed patients. Some strategies for improving follow-up care include confirming appointment at discharge; tracking and communication with outside providers; recontacting patients who do not keep their appointments; and reviewing follow-up care monthly to identify system problems (Quality Profiles, 2005).

Measure Definition

The *Follow-Up After Hospitalization for Mental Illness* measure shows the following**.**

- The percentage of discharges for members who had an ambulatory or day/night mental health visit on the date of discharge, up to *7 days* after hospital discharge.
- The percentage of discharges for members who had an ambulatory or day/night mental health visit on the date of discharge, up to *30 days* after hospital discharge.

Data Collection Methodology

This measure is collected using administrative methodology.

Summary of Changes

There were no significant changes.

Star Performer

The 30-day measure is included in the *2006/2007 Consumer Guide*; therefore, it is eligible for Star Performer designation.

Notes

Several factors complicate calculating this measure and can lead to underreporting. When interpreting results, readers should consider the following.

- The eligible population for this measure is based on discharges, not on members. The denominator can contain multiple discharges for one individual if the discharges occurred more than 30 days apart.
- Since hospitalizations for mental illness do not occur frequently, the number of people who should have received services measured in this report is often small.
- Mental health services are often not administered by HMO providers. HMOs may contract with external organizations—MBHOs—to provide mental health services, and therefore, may not always receive complete data from their vendors. Incomplete or missing data will influence an HMOs' ability to accurately calculate this measure.

Results

- Comparison of the rates for the two measures showed that on average, 75% of eligible members received a follow-up visit within 30 days of hospital discharge, while 58% of eligible members received a follow-up within 7 days of hospital discharge.
- The 3-year trend shows an increase in eligible members who receive timely follow-up care. Since 2004, both the 30-day and 7-day rate increased by 5 percentage points.

7-Day Measure (see Table 87)

- Rates ranged from 50%–67%, with two plans receiving above-average scores, four plans receiving average scores, and one plan receiving a below-average score.
- Three plans showed statistically significant gains from 2004.

30-Day Measure (see Tables 88)

- Rates ranged from 65%–83%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.
- Three plans also showed statistically significant gains from 2004 and four plans showed increases of 5 or more percentage points.

Table 87

Follow-up After Hospitalization for Mental Illness, 7 Days, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**53%**	**55%**	**58%**	**5%**			
Aetna	56%	58%	55%	⇔	★★	★★	★★
BlueChoice	45%	55%	62%	🡅	★	★★	★★★
CIGNA	54%	46%	59%	⇔	★★	★	★★
Coventry	47%	52%	50%	⇔	★	★★	★
Kaiser Permanente	65%	66%	67%	⇔	★★★	★★★	★★★
M.D. IPA	49%	55%	57%	🡅	★	★★	★★
OCI	54%	58%	59%	🡅	★★	★★	★★

Table 88

Follow-up After Hospitalization for Mental Illness, 30 Days, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**70%**	**73%**	**75%**	**5%**			
Aetna	75%	76%	72%	⇔	★★★	★★★	★★
BlueChoice	66%	72%	75%	🡅	★	★★	★★
CIGNA	67%	65%	76%	🡅	★★	★	★★
Coventry	65%	72%	65%	⇔	★★	★★	★
Kaiser Permanente	73%	73%	75%	⇔	★★	★★	★★
M.D. IPA	72%	80%	77%	⇔	★★	★★★	★★
OCI	74%	75%	83%	🡅	★★★	★★	★★★

Legend

Change 2004–2006

- 🡅 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡇 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

ANTIDEPRESSANT MEDICATION MANAGEMENT

Background

Depression ranks high as a chronic condition encountered by primary care physicians. It is estimated that in the United States, 32.6–35.1 million people (about 15% of the population) will suffer from a major depressive disorder in their life (JAMA, 2003). In a given year, an estimated 17.1 million American adults suffer from a depressive disorder (JAMA, 2003). According to the National Institute of Mental Health, depressive disorders affect nearly twice as many women than men and have begun appearing more frequently in children and adolescents in the recent decade. The prevalence of depression in children and adolescents has been found to be about 5% (American Academy of Child and Adolescent Psychiatry, 2004), and moreover, it has been discovered that half of those who will be diagnosed with a mental illness show signs of the illness by age 14 years, yet mental illness in children and adolescents is often overlooked (NIMH, 2005).

When pharmacological therapy is initiated, the American Medical Association defines three phases of antidepressive treatment: acute, continuation, and maintenance. Many patients who have a moderate to severe case of depression are generally good candidates for treatment with antidepressant medication; however, treatment must be monitored to ensure effectiveness. Premature discontinuation is associated with higher rates of depression relapse and major depressive episodes (Melartin et al., 2005). Of primary care patients diagnosed with depression, 40%–50% discontinue treatment within the first three months (Simon, 2002), and another 50% discontinue antidepressant medications during the maintenance phase of treatment (Acta Psychiatrica Scandinavica**,** 2002).

Measure Definition

The *Antidepressant Medication Management* measure assesses three different facets of successful pharmacological management of depression.

1. *Optimal Practitioner Contacts for Medication Management*: Percentage of plan members 18 years and older, newly diagnosed with depression and treated with antidepressant medication, who had at least three follow-up contacts with a primary care or mental health practitioner, at least one of whom is a prescribing practitioner, during an 84-day acute treatment phase.

2. *Effective Acute Phase Treatment*: Percentage of plan members 18 years and older, newly-diagnosed with depression and treated with antidepressant medication, who remained on antidepressant medication during an 84-day acute treatment phase.

3. *Effective Continuation Phase Treatment*: Percentage of plan members 18 years and older, newly-diagnosed with depression and treated with antidepressant medication, who remained on an antidepressant medication for at least 180 days.

Data Collection Methodology

This measure is collected using administrative methodology.

Summary of Changes

- A definition for "treatment days" was added.
- The measure was clarified to reference April 30 instead of 120 days of the year to allow consistent programming each year.

Star Performer

Portions of this measure are included in the *2006/2007 Consumer Guide*; therefore, they are eligible for Star Performer designation.

Notes

Like the measure *Follow-Up After Hospitalization for Mental Illness,* some unique issues may affect these results. Coordinating data collection may pose a challenge. Five of the seven Maryland plans contract with an MBHO to provide behavioral health services to members, but not all employers contract with health plans for behavioral health benefits. Prescription drug plans are also often separate from health plan membership. Even when the plan holds the contract with other providers and can request data, integrating data from the plan's own providers and from outside contractors adds an additional step to data collection efforts and may result in the omission of some data.

Results *(see Tables 89–91)*

Optimal Practitioner Contacts for Medication Management

- Rates ranged from 12%–25%, with two plans receiving above-average scores, three plans receiving average scores, and two plans receiving below-average scores.
- One plan received a Star Performer designation.

Effective Acute Phase Treatment

- From 2004–2006, the Maryland HMO/POS plan average increased by 1 percentage point to 62%.
- While most plans experienced small, nonsignificant rate gains, one plan experienced a statistically significant seven percentage point decrease.
- In 2006, rates ranged from 56%–68%, with one plan receiving an above-average score, five plans receiving average scores, and one plan receiving a below-average score.

Effective Continuation Phase Treatment

- From 2004–2006, the Maryland HMO/POS average increased 1 percentage point to 44%.
- Two of the seven plans reporting for all three years significantly improved their rate, while two plans had significant decreases of six percentage points.
- In 2006, rates ranged from 40%–50%, with one plan receiving an above-average score, four plans receiving average scores, and two plans receiving below-average scores.

Table 89

Antidepressant Medication Management, Optimal Practitioner Contacts, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**22%**	**19%**	**20%**	**-2%**			
Aetna	23%	18%	22%	⇔	★★	★★	★★
BlueChoice	18%	14%	12%	🡻	★	★	★
CIGNA	23%	21%	23%	⇔	★★	★★	★★
Coventry	23%	18%	18%	⇔	★★	★★	★★
Kaiser Permanente	16%	15%	18%	🡹	★	★	★
M.D. IPA	26%	26%	25%	⇔	★★★	★★★	★★★★
OCI	24%	22%	22%	⇔	★★	★★★	★★★

Table 90

Antidepressant Medication Management, Effective Acute Phase Treatment, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**61%**	**62%**	**62%**	**1%**			
Aetna	63%	62%	64%	⇔	★★	★★	★★
BlueChoice	64%	65%	68%	⇔	★★★	★★★	★★★
CIGNA	61%	63%	61%	⇔	★★	★★	★★
Coventry	59%	55%	62%	⇔	★★	★	★★
Kaiser Permanente	63%	68%	56%	🡻	★★★	★★★	★
M.D. IPA	57%	63%	58%	⇔	★	★★	★★
OCI	59%	61%	62%	⇔	★★	★★	★★

Legend

Change 2004–2006

- 🡹 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡻 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★★ = Star Performer—This designation indicates the plan achieved a better-than-average relative rate for this measure for three consecutive reporting years (2004–2006).
- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 91

Antidepressant Medication Management, Effective Continuation Phase Treatment, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**43%**	**43%**	**44%**	**1%**			
Aetna	43%	46%	50%	⇑	★★	★★	★★★
BlueChoice	47%	48%	41%	⇓	★★★	★★★	★
CIGNA	49%	43%	44%	⇔	★★★	★★	★★
Coventry	41%	30%	47%	⇔	★★	★	★★
Kaiser Permanente	46%	52%	40%	⇓	★★★	★★★	★
M.D. IPA	37%	40%	40%	⇔	★	★★	★★
OCI	40%	40%	43%	⇑	★	★	★★

Legend

Change 2004–2006

⇑ Plan rate increased significantly from 2004 to 2006.
⇔ Plan rate *did not* change significantly from 2004 to 2006.
⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

★★★ = Plan performed significantly better than the Maryland HMO/POS average.
★★ = Plan performed equivalent to the Maryland HMO/POS average.
★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

MENTAL HEALTH UTILIZATION—INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY

Measure Definition

The *Mental Health Utilization-Inpatient Discharges and Average Length of Stay* performance measure estimates how many hospitalizations for mental health disorders occurred during 2005 and how long patients stayed in the hospital, on average. The measure includes only members who had behavioral health coverage with their health plan. If the health plan contracts with another provider, the plan is responsible for collecting and reporting those data. Rates are per 1,000 members with mental health coverage. Data are not included here if members receive services outside their health plan as a result of behavioral health services being excluded from coverage.

Notes

Ensuring the completeness of behavioral health data from vendors and compiling the data with internal behavioral service information has not been an area of plan strength. As a result, data completeness issues can decrease plan utilization rates.

Results *(see Table 92)*

- The Maryland HMO/POS average rate of hospitalizations for all mental disorders was 3.1 discharges per 1,000 members.
- The 2006 rates ranged from 2.2 discharges per 1,000 members to 3.7 discharges per 1,000 members.
- Average length of stay ranged from 5.3–6.3 days per 1,000 members.

Table 92

Mental Health Utilization -- Inpatient Discharges and Average Length of Stay, 2006 Results		
	Discharges/1,000 Members	**ALOS (Days)**
Maryland HMO/POS Average	**3.1**	**5.9**
Aetna	3.2	6.0
BlueChoice	2.8	6.0
CIGNA	3.4	6.3
Coventry	2.2	5.3
Kaiser Permanente	2.9	5.8
M.D. IPA	3.7	5.8
OCI	3.6	5.9

MENTAL HEALTH UTILIZATION—PERCENTAGE OF MEMBERS RECEIVING ANY SERVICES

Measure Definition

The *Mental Health Utilization-Percentage of Members Receiving Any Services* performance measure reports the percentage of members who received the following types of mental health services.

- Inpatient hospital treatment
- Intermediate care (a level of care where a patient may live at home and visit a therapeutic institution during the day)
- Ambulatory treatment

This measure also provides information about access to mental health services. Rates are expressed as a percentage.

Results *(see Table 93)*

- Across Maryland HMOs, 5.11% of all members with behavioral health coverage received some type of behavioral health service in 2005.
- Rates of members receiving any service ranged from 4.83%–5.80%.

Rates for hospital treatment (inpatient), intermediate care, and ambulatory treatment are included in the report to facilitate comparison and analysis by plans, providers, and other organizations.

Table 93

Mental Health Utilization - Any Services, 2006 Results								
	Any		Inpatient		Intermediate		Ambulatory	
	Num	Pct	Num	Pct	Num	Pct	Num	Pct
Maryland HMO/POS Average	**17,274**	**5.11%**	**832**	**0.24%**	**201**	**0.05%**	**16,939**	**5.02%**
Aetna	15,385	4.92%	699	0.22%	250	0.08%	15,290	4.89%
BlueChoice	32,479	5.80%	1,286	0.23%	349	0.06%	32,130	5.74%
CIGNA	11,727	5.13%	606	0.27%	70	0.03%	11,549	5.05%
Coventry	4,897	5.14%	177	0.19%	12	0.01%	4,844	5.08%
Kaiser Permanente	22,070	4.98%	1,059	0.24%	173	0.04%	21,334	4.81%
M.D. IPA	10,075	5.00%	564	0.28%	155	0.08%	9,806	4.87%
OCI	24,283	4.83%	1,430	0.28%	400	0.08%	23,622	4.70%

Note: *The sum of the number of members who received various services does not equal the number of members who received any service because some members received more than one type of service.*

CHEMICAL DEPENDENCY UTILIZATION—INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY

According to the Office of Applied Studies, Substance Abuse and Mental Health Services (SAMHSA), in 2004, 22.5 million Americans ages 12 years or older (9.4% of the population) were classified with past-year substance dependence or abuse, which is about the same prevalence in 2002 and 2003. Of these, 3.4 million were classified with dependence on, or abuse of, both alcohol and illicit drugs, 3.9 million were dependent on or abused illicit drugs but not alcohol, and 15.2 million were dependent on or abused alcohol but not illicit drugs.

Measure Definition

The *Chemical Dependency Utilization-Inpatient Discharges and Average Length of Stay* performance measure reports how many hospitalizations for chemical dependency occurred during 2005 and how long patients stayed in the hospital, on average. The single most common type of treatment sought is for alcohol dependence. The measure includes only members whose health care benefits include coverage for chemical dependence. Rates are per 1,000 members with chemical dependency coverage.

Notes

As is the case for all data related to behavioral health, incompleteness of data on use of chemical dependency services may reflect underreporting. Data collection problems are connected to how these services are delivered—often via contractors rather than through health plans.

Results *(see Table 94)*

- From 2005 to 2006, the Maryland HMO/POS average increased from 0.8 discharges per 1,000 members to 0.9 discharges per 1,000 members.
- Rates ranged from 0.7 discharges per 1,000 members to 1.1 discharges per 1,000 members.
- From 2005 to 2006, the Maryland average HMO/POS average length of stay increased slightly, from 3.8 days to 4.2 days, and ranged from 3.6 days to 5.1 days.

Table 94

Chemical Dependency Utilization Inpatient Discharges and Average Length of Stay, 2006 Results		
	Discharges/1,000 Members	**ALOS (Days)**
Maryland HMO/POS Average	**0.9**	**4.2**
Aetna	0.8	4.1
BlueChoice	1.1	4.0
CIGNA	0.8	5.1
Coventry	0.9	4.5
Kaiser Permanente	1.1	4.3
M.D. IPA	0.7	3.8
OCI	0.9	3.6

IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES

Background

Substance abuse is costly to the individual, family, and health care system. Addiction to alcohol and drugs is associated with many diseases and disorders, not to mention the countless accidents that occur as a result. In 2004, an estimated 22.5 million Americans ages 12 years or older (9.4% of the population) were classified with dependence on or abuse of either alcohol or illicit drugs (SAMHSA, 2005). The USPSTF recommends screening and behavioral health counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings (AHRQ, 2005).

Measure Definition

The *Identification of Alcohol and Other Drug* Services measure reports the number and percentage of members with an alcohol or other drug (AOD) claim. These claims contain a diagnosis of AOD abuse or dependence and one of the following AOD-related services during the measurement year.

- Inpatient hospital treatment
- Intermediate care
- Ambulatory treatment

Summary of Changes to HEDIS 2006

There were no significant changes to this measure.

Results *(see Table 95)*

- Across Maryland HMOs, 0.69% of all members with substance abuse coverage had alcohol or other drug claims for services rendered in 2005.
- Rates of members receiving any service ranged from 0.35%–1.07%.

Rates for hospital treatment (inpatient), intermediate care, and ambulatory treatment are included in the report to facilitate comparison and analysis by plans, providers, and other organizations. There are minimal differences across plans, as rates for each level of care are less than 1%.

Table 95

Identification of Alcohol and Other Drug Services - Percentage of Members Receiving Services, 2006 Results

	Any Services		Inpatient Services		Intermediate Services		Ambulatory Services	
	Num	Pct	Num	Pct	Num	Pct	Num	Pct
Maryland HMO/POS Average	**2,477**	**0.69%**	**965**	**0.26%**	**205**	**0.05%**	**1,729**	**0.49%**
Aetna	1,090	0.35%	185	0.06%	217	0.07%	964	0.31%
BlueChoice	6,007	1.07%	1,943	0.35%	694	0.12%	4,517	0.81%
CIGNA	1,251	0.55%	503	0.22%	21	0.01%	878	0.38%
Coventry	755	0.79%	191	0.20%	8	0.01%	632	0.66%
Kaiser Permanente	3,613	0.81%	2,170	0.49%	113	0.03%	1,712	0.39%
M.D. IPA	1,140	0.57%	510	0.25%	75	0.04%	764	0.38%
OCI	3,484	0.69%	1,252	0.25%	306	0.06%	2,637	0.52%

Note: *The sum of the number of members who receive various services does not equal the number of members who received any service because some members receive more than one type of service.*

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Background

The impact of addiction to alcohol and other drugs can be far reaching. Cardiovascular disease, stroke, cancer, HIV/AIDS, hepatitis, and lung disease can all be affected by drug and alcohol abuse. Alcohol use accounts for 85,000 deaths (3.5%) in the United States annually. It is one of the largest preventable causes of death (JAMA, 2004). According to the National Institute on Alcohol and Alcoholism, the cost of alcohol abuse on society is approximately $85 billion annually, while other drug use can cost approximately $47 billion.

In 2004, 3.8 million Americans over the age of 12 years (1.6% of the population) received AOD treatment (SAMHSA, 2005); however, it has been reported that less than 25% of those who need treatment for AOD abuse get it (Schneider Institute for Health Policy, 2001). With proper treatment, AOD dependence can be overcome. Research supports not only the need for individuals to cease using addictive substances, but also to engage in ongoing treatment to prevent relapse.

Measure Definition

The *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measures assess the degree to which plans initiate and engage adolescent (13–17 years) and adult (18 years and older) members identified with AOD dependence.

Initiation: The percentage of adolescents and adults diagnosed with AOD dependence who initiate treatment through either:

- an inpatient admission
- outpatient treatment and additional AOD treatment within 14 days

Engagement: The percentage of adolescents and adults diagnosed with AOD dependence who receive two additional AOD services within 30 days after treatment initiation.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes to HEDIS 2006

An adolescent age band (13–17 years) was added as a first-year indicator.

Star Performer

The *Initiation* measure was reported in the *2006/2007 Consumer Guide*; therefore, it is eligible for Star Performer designation.

Results *(see Tables 96-97)*

Initiation of Alcohol and Other Drug Dependence

- The average rate for all Maryland HMO/POS plans was 46%, while plan rates ranged from 31%–65%.
- The average percentage point change for 2004–2006 was 11%; however, this measure showed a great deal of rate variability.
- One plan received an above-average score, three plans received average scores, and three plans received below-average scores.

Engagement of AOD Dependence

- Plans show much lower alcohol and drug treatment engagement rates than seen in treatment initiation. The Maryland HMO/POS average rate for engagement in 2006 was 14%, compared to the 46% seen in initiation rates.
- Between 2004 and 2006, this rate dropped by an average of 4 percentage points. One plan had a statistically significant increase in its rate, three had no significant change, and three had a statistically significant decrease in rate.
- Two of the seven plans received above-average scores, one plan received an average score, and four plans received below-average scores.

Table 96

Initiation of Alcohol and Other Drug Treatment, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**35%**	**44%**	**46%**	**11%**			
Aetna	47%	48%	48%	⇔	★★★	★★★	★★
BlueChoice	33%	36%	31%	⇔	★	★	★
CIGNA	56%	35%	48%	🡻	★★★	★	★★
Coventry	39%	45%	38%	⇔	★★★	★★	★
Kaiser Permanente	29%	51%	65%	🡹	★	★★★	★★★
M.D. IPA	20%	49%	46%	🡹	★	★★★	★★
OCI	22%	47%	43%	🡹	★	★★★	★

Table 97

Engagement of Alcohol and Other Drug Treatment, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**18%**	**14%**	**14%**	**-4%**			
Aetna	19%	13%	12%	🡻	★★	★★	★
BlueChoice	20%	24%	19%	⇔	★★★	★★★	★★★
CIGNA	24%	9%	10%	🡻	★★★	★	★
Coventry	17%	12%	10%	🡻	★★	★★	★
Kaiser Permanente	17%	16%	22%	🡹	★★	★★★	★★★
M.D. IPA	12%	13%	10%	⇔	★	★★	★
OCI	15%	14%	15%	⇔	★	★★	★★

Legend

Change 2004–2006

- 🡹 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡻 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

BEHAVIORAL HEALTHCARE PROVIDERS

Background

This measure was developed by the MHCC to collect data on the number and types of behavioral healthcare providers available to members through their plan. Many health plans contract with MBHOs to provide care to some or all of their members. These organizations, specializing in providing mental health and chemical dependency services, have their own network of physicians and other behavioral health practitioners. MBHOs can also have specific policies for accessing behavioral health services, including the need for a referral, limits on coverage, and copayments that may be different from HMO policies.

> *In 1994, Maryland State Legislators passed a mental health parity law that prohibits insurance companies from discriminating against an individual with a mental illness, emotional disorder, drug abuse disorder or alcohol abuse disorder by failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply under the policy or contract for the diagnosis or treatment of physical illnesses. It covers all insurance plans and HMOs (Health Management Organizations) except the Comprehensive Standard Health Benefit Plan and the Limited Benefit Plan.*
>
> *There is no separate limit on benefits for psychiatric care annually or over the lifetime of the insured.*

When care is delivered and no problems arise, the contractual relationship between an HMO and an MBHO may be transparent to members. Obtaining health plan referrals for behavioral health services has been an area of great concern for HMO members.

Measure Definition

This MHCC-specific *Behavioral Healthcare Providers* performance measure reports the total number of providers per 1,000 members with behavioral health benefits for each behavioral health network. Only providers who serve members enrolled within the commercial product of the health plan are counted. Providers may be employed by the HMO, have a contractual relationship with the HMO, or have a contractual relationship with the MBHO responsible for managing and providing care for HMO members. The total number of providers includes the following.

- Psychiatrists
- Psychologists
- Other behavioral health providers (includes certified professional counselors, social workers, and nurse psychotherapists)

Results *(see Tables 98–99)*

The measure shows a comparison of the total provider network available to members of the various plans. The number of providers available is compared for an equal number of members across each plan and reported as providers per 1,000 members. A larger number of providers may improve access to care by giving members more choices in who they see, appointment times, and locations.

Total Providers

The Maryland HMO/POS average for number of total providers is 11.2 per 1,000 members. Rates ranged from 3.5–27.5 providers per 1,000 members. The number of behavioral health providers in the MBHO and plan network per 1,000 members as of spring 2006 are shown on Table 98.

Psychiatrists (MD) Board Certification

The Maryland HMO/POS average for the percentage of psychiatrists who are board-certified psychiatrists (MD) is 69%. Rates ranged from 61%–74%. The percentage of psychiatrists who are board certified as of spring, 2006 are shown on Table 99.

Table 98: Plans' Total Number of Behavioral Healthcare Providers

Health Plan	MBHO	Total Number of Behaviorlal Health Providers in MBHO and Plan Network as of Spring 2006 (per 1000 members)*
Maryland HMO/POS Average		11.2
Aetna	Magellan Behavioral Health-King of Prussia Regional Service Center	10.8
BlueChoice	Magellan Behavioral Health-Mid Atlantic Service Center	5.0
CIGNA	CIGNA Behavioral Health	3.5
Coventry	United Behavioral Health-Chesapeake	27.5
Kaiser Permanente**	Plan Network Providers	4.0
	APS	
M.D. IPA	Plan Network Providers	19.3
OCI	Plan Network Providers	8.6

Table 99: Plans' Percentage of Psychiatrists Who Are Board Certified

Health Plan	MBHO	Percentage of Psychiatrists Who are Board Certified
Maryland HMO/POS Average		**69%**
Aetna	Magellan Behavioral Health- King of Prussia Regional Service Center	61%
BlueChoice	Magellan Behavioral Health- Mid Atlantic Service Center	66%
CIGNA	CIGNA Behavioral Health- Chesapeake	70%
Coventry	United Behavioral Health- Atlanta Regional Care Center	74%
Kaiser Permanente**	Plan Network Providers APS Healthcare	70%
M.D. IPA	Plan Network Providers	71%
OCI	Plan Network Providers	70%

Notes

* Number of providers is based upon the service area of the plan. The MBHO network may have a larger number of practitioners than reported in this Guide.

** During 2006, Kaiser Permanente began changing to an in-house only network of behavioral health providers except for plan members in the Baltimore area. As the network arrangement for members changes, the rate of providers per 1,000 members will also change. Currently, only Kaiser members whose personal physician is located in Baltimore will receive and have their services administered by APS Healthcare, Inc. All members of Kaiser have access to the in-house network of behavioral health providers. The rate above represents an average distribution of providers for the combined networks across covered members. For further details, contact Kaiser Permanente.

HEALTH PLAN
DESCRIPTIVE INFORMATION

HEALTH PLAN DESCRIPTIVE INFORMATION

Overview

This section contains results for the HEDIS 2006 *Health Plan Descriptive Information* measures that MHCC required Maryland commercial HMOs to report in 2006. It includes information on health plan structure, staffing, and enrollment. Purchasers and consumers are interested in the qualifications of doctors in the health plan and in member patterns, which can reveal potential signs of instability. For example, a sudden decrease in membership may indicate member dissatisfaction. Likewise, a sudden increase in membership due to merger/acquisition may raise questions about a plan's capacity to ensure access to care among its expanded membership base. The following measures address these issues.

Measures in Domain

- Board Certification
- Enrollment: Total, By State, By Product

BOARD CERTIFICATION

Background

Board certification is often used as a proxy to measure physician quality. This measure shows what percentage of the health plan's physicians sought and obtained board certification; it does not directly measure the quality of individual physicians. Virtually all medical specialty boards certify physicians who complete specified training and pass an examination in that specialty. Board certification shows that a physician has an extended knowledge of a specialty that may be important to purchasers and consumers. Board certification alone is not a guarantee of quality. Some physicians have valid reasons why they have not sought and obtained board certification. A plan might have a lower percentage of board-certified physicians if it has a higher proportion of older physicians who began their practice before board certification was established. Similarly, a plan's rate may be lower if the plan is located in a rural area where shortage of a particular type of physician is common.

Measure Definition

The *Board Certification* measure reports the percentage of the following *physician* practitioners who are board certified.

- Primary care physician practitioners
- OB/GYN practitioners
- Pediatric practitioner specialists*
- All other practitioner specialists

Board certification refers to the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association.

Summary of Changes to HEDIS 2006

There are no significant changes to this measure.

Star Performer

These measures are not reported in the *2006/2007 Consumer Guide*; therefore, they are not eligible for Star Performer designation.

*Physicians designated by the plan as providing pediatric-focused specialty care.

Results *(see Tables 100-104)*

Comparison of 2006 Maryland average HMO/POS results across provider types show some variation of Board Certification rates. Certification rates by specialty range from 72%–93% for pediatric practitioner specialists, OB/GYN practitioners, other practitioner specialists, and primary care practitioners.

Primary Care Physician Practitioners (see Tables 100, 101)

- From 2004–2006, two of the seven plans significantly increased their rate. The Maryland HMO/POS average did not change over this period.
- In 2006, rates ranged from 77%–93%, with two plans receiving above-average scores, two plans receiving average scores, and three plans receiving below-average scores.

OB/GYN Practitioners (see Tables 100, 102)

- From 2004–2006, only one of the seven plans significantly increased its rate. The Maryland HMO/POS average did not change over this period.
- In 2006, rates ranged from 72%–89%, with two plans receiving above-average scores, two plans receiving average scores, and three plans receiving below-average scores.

Pediatric Practitioner Specialists (see Tables 100, 103)

- From 2004–2006, only one of the seven plans significantly increased its rate. The Maryland HMO/POS average decreased 1 percentage point over this period.
- In 2006, rates ranged from 70%–83%, with five plans receiving average scores and two plans receiving below-average scores.

Other Practitioner Specialists (see Tables 100, 104)

- From 2004–2006, only one of the seven plans significantly increased its rate. The Maryland HMO/POS average decreased 1 percentage point over this period.
- In 2006, rates ranged from 74%–85%, with four plans receiving above-average scores and three plans receiving below-average scores.

Overall Trends

- From 2004–2006, two plans' rates decreased significantly in all categories.
- Two plans performed significantly better than the Maryland HMO/POS average in three of the four categories.

Table 100

Board Certification, 2006 Results								
	PCP		OB/GYN		Pediatric		Other Specialists	
Maryland HMO/POS Average	**84%**		**79%**		**78%**		**80%**	
Aetna	83%	★★	79%	★★	70%	★	74%	★
BlueChoice	82%	★	76%	★	83%	★★	81%	★★★
CIGNA	88%	★★★	85%	★★★	72%	★	82%	★★★
Coventry	84%	★★	77%	★★	82%	★★	84%	★★★
Kaiser Permanente	93%	★★★	89%	★★★	79%	★★	85%	★★★
M.D. IPA	79%	★	73%	★	81%	★★	77%	★
OCI	77%	★	72%	★	81%	★★	77%	★

Table 101

Primary Care Practitioner, Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**84%**	**84%**	**84%**	**0%**			
Aetna	83%	85%	83%	⇔	★★	★★★	★★
BlueChoice	77%	80%	82%	🡅	★	★	★
CIGNA	81%	81%	88%	🡅	★	★	★★★
Coventry	89%	85%	84%	🡇	★★★	★★	★★
Kaiser Permanente	92%	93%	93%	⇔	★★★	★★★	★★★
M.D. IPA	82%	82%	79%	🡇	★	★	★
OCI	80%	81%	77%	🡇	★	★	★

Legend

Change 2004–2006

- 🡅 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡇 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 102

OB/GYN Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**79%**	**79%**	**79%**	**0%**			
Aetna	80%	81%	79%	⇔	★★	★★★	★★
BlueChoice	73%	75%	76%	⇔	★	★	★
CIGNA	74%	75%	85%	⇑	★	★	★★★
Coventry	79%	78%	77%	⇔	★★	★★	★★
Kaiser Permanente	90%	91%	89%	⇔	★★★	★★★	★★★
M.D. IPA	80%	77%	73%	⇓	★★	★★	★
OCI	79%	77%	72%	⇓	★★	★	★

Table 103

Pediatric Specialist Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**79%**	**81%**	**78%**	**-1%**			
Aetna	68%	68%	70%	⇔	★	★	★
BlueChoice	79%	81%	83%	⇔	★★	★★	★★
CIGNA	63%	64%	72%	⇑	★	★	★
Coventry	89%	87%	82%	⇓	★★★	★★★	★★
Kaiser Permanente	89%	100%	79%	⇔	★★	★★★	★★
M.D. IPA	84%	85%	81%	⇓	★★★	★★★	★★
OCI	84%	84%	81%	⇓	★★★	★★★	★★

Legend

Change 2004–2006

- ⇑ Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- ⇓ Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 104

Other Specialist Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**81%**	**81%**	**80%**	**-1%**			
Aetna	76%	75%	74%	🡻	★	★	★
BlueChoice	81%	82%	81%	⇔	★★	★★	★★★
CIGNA	73%	74%	82%	🡹	★	★	★★★
Coventry	89%	87%	84%	🡻	★★★	★★★	★★★
Kaiser Permanente	85%	90%	85%	⇔	★★★	★★★	★★★
M.D. IPA	82%	81%	77%	🡻	★★★	★	★
OCI	81%	80%	77%	🡻	★★	★	★

Legend

Change 2004–2006

- 🡹 Plan rate increased significantly from 2004 to 2006.
- ⇔ Plan rate *did not* change significantly from 2004 to 2006.
- 🡻 Plan rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

TOTAL ENROLLMENT

Background

Enrollment information conveys the size of the population a health plan serves. Being aware of the size of each health plan may be useful in interpreting some results presented in previous sections. Although quality and health plan size do not have a direct association, changes in enrollment size can have a measurable impact on member and provider satisfaction.

Member retention is an increasingly important issue for health plans to address. Health plans experience a cost investment to acquire a commercial member. For this reason, the way members rate their health plan is not only an important indicator of plan quality, but it is also important for retaining members. Health plan rating is the most heavily weighted CAHPS survey question in the HEDIS audit process. Factors that influence how members rate their plan include the quality of service provided by the plan, the quality of care provided by the plan, and the cost of the plan to the member. Analysis of aggregate results from the 2006 CAHPS adult commercial survey of Maryland plan members shows that, on average, the key drivers of overall satisfaction among Maryland plans score below the 50th percentile when compared to Quality Compass 2006. The key drivers of overall satisfaction consist of member satisfaction with a plan's claims processing, customer service, and access to getting needed care.

Measure Definition

Enrollment by Product Line

The *Enrollment by Product Line* measure shows the number of member years contributed by members to the health plan during 2005. Member years are closely associated with the number of members in the health plan.

Enrollment by State

The new measure, *Enrollment by State,* shows the number of members enrolled any time during 2005 by state.

Summary of Changes to HEDIS 2006

The *Total Enrollment by Percentage* measure was retired.

Notes

For the *Enrollment by Product Line* measure, the enrollment figures are for each plan's entire population, stratified by age and total enrollment. Figures include Maryland residents and may include members residing in service areas of Washington, D.C., Northern Virginia, Richmond, Delaware, southern New Jersey, southeastern Pennsylvania, and West Virginia, depending on the geographic configuration of the HMO.

Enrollment figures for all plans, except Kaiser, include membership in HMO and POS products. Kaiser reports HEDIS rates based on the HMO product alone.

Results

Enrollment by Product Line (see Table 105)

- The total enrollment for Maryland commercial HMO/POS plans by member years is estimated at 2.4 million, with the average plan having approximately 348,000 members. Plan membership ranges widely, from 98,903–560,134.
- From 2005–2006, total enrollment in the seven Maryland commercial HMO/POS plans increased by 6.2%. Compared to 2005 average plan enrollment figures, an increase was seen in three of the seven plans (CIGNA*, Coventry, and BlueChoice). This marks the third year that BlueChoice showed an increase in total enrollment.

Enrollment by State (see Table 106)

- Maryland residents make up 1.5 million or 53% of members belonging to Maryland commercial HMO/POS plans.

* CIGNA merged with its Virginia plan to form one HMO servicing members in both Maryland and Virginia.

Table 105

Enrollment by Product Line (Member Years) in 2006															
	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total	Total	Total
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	2006	2005	2004
Maryland HMO/POS Average	51,701	49,871	101,572	63,996	74,242	138,238	47,950	52,348	100,298	3,978	3,692	7,670	347,779	327,341	324,266
Maryland Total	361,907	349,099	711,006	447,974	519,692	967,666	335,650	366,436	702,086	27,847	25,846	53,693	2,434,451	2,291,389	2,269,864
Aetna	50,582	48,744	99,326	56,058	66,804	122,862	39,570	44,000	83,570	3,579	3,432	7,011	312,769	337,317	336,045
BlueChoice	77,572	75,307	152,879	118,520	138,607	257,127	69,411	77,244	146,655	1,850	1,623	3,473	560,134	494,693	433,457
CIGNA	42,509	41,043	83,552	52,003	56,755	108,758	42,153	41,137	83,290	2,337	1,868	4,205	279,805	152,160	177,517
Coventry	14,293	13,551	27,844	16,993	18,478	35,471	15,157	16,139	31,296	2,195	2,097	4,292	98,903	97,586	101,304
Kaiser Permanente	64,351	62,262	126,613	73,704	90,357	164,061	64,008	75,680	139,688	6,651	6,553	13,204	443,566	444,088	456,597
M.D. IPA	38,390	37,031	75,421	34,355	43,878	78,233	34,139	37,653	71,792	4,708	4,334	9,042	234,488	243,659	239,351
OCI	74,210	71,161	145,371	96,341	104,813	201,154	71,212	74,583	145,795	6,527	5,939	12,466	504,786	521,886	525,593

Enrollment data for 2005 and 2004 are included for comparative purposes.

Table 106

Enrollment by State, 2006									
	Maryland	Delaware	District of Columbia	New Jersey	Pennsylvania	Virginia	West Virginia	Other	Total
Maryland HMO/POS Average	**53.36%**	**9.41%**	**4.32%**	**0.14%**	**1.23%**	**30.01%**	**0.84%**	**0.69%**	**100%**
Total State Enrollment	**1,452,679**	**86,199**	**124,931**	**1,773**	**25,238**	**770,890**	**23,057**	**20,238**	**2,505,005**
Aetna	59.02%	0.09%	6.92%	0.12%	0.55%	32.77%	0.21%	0.32%	313,962
BlueChoice	76.77%	0.24%	4.76%	0.02%	1.22%	15.01%	0.43%	1.55%	574,976
CIGNA	24.70%	0.03%	1.87%	0.08%	0.28%	70.79%	1.33%	0.92%	286,127
Coventry	32.67%	62.25%	0.03%	0.72%	3.80%	0.17%	0.02%	0.34%	111,651
Kaiser Permanente	51.65%	0.04%	9.52%	0.03%	0.24%	37.30%	0.22%	1.00%	510,182
M.D. IPA	64.46%	0.23%	4.98%	0.01%	0.71%	28.16%	1.02%	0.42%	232,449
OCI	64.23%	2.99%	2.15%	0.02%	1.80%	25.90%	2.65%	0.26%	475,658

HEALTH PLAN STABILITY

HEALTH PLAN STABILITY

Overview

This section presents results for a measure in the HEDIS *Health Plan Stability* domain that MHCC required Maryland HMOs to report in 2006. When reviewing other aspects of health plan performance, past performance can be a good predictor of future performance, assuming that a plan's structure and health care delivery system remain reasonably stable.

In 2006, commercial plans in Maryland reported *Practitioner Turnover* as an indicator of stability.

PRACTITIONER TURNOVER

Background

The percentage of practitioners who leave a health plan may have implications for the quality of health care that members receive. Although there is little evidence that high turnover has an impact on the quality of care for acute illness, several studies have shown that continuity of practitioners in treating chronic illnesses is desirable. In addition, for most patients, an ongoing relationship increases the level of comfort with their physician. Some practitioner turnover is normal and expected due to individual changes in circumstances, such as relocation or retirement; however, high rates of practitioner turnover may be a sign of practitioner dissatisfaction with the health plan. Conversely, plans may end contracts with practitioners who do not adhere to administrative or health care standards. A study released in 2006 in the *New England Journal of Medicine* (NEJM) showed that 70% of physicians in medical groups left voluntarily, 13% retired, and 16% were terminated. Of those who left voluntarily, 44% left due to dissatisfaction with their practice, followed by compensation and location issues (21%).

The NEJM study found the average annual physician turnover rate to be 6.4%. Physician turnover has the potential to not only cost the health care industry hundreds of millions of dollars per year, but it can affect patients as well. Physician turnover negatively affects the performance of remaining physicians in a group practice because it increases their workload and decreases morale (NEJM, 2006). Additionally, the cost to recruit and replace primary care physicians (PCP) averages about $250,000 per doctor, and it is even more expensive to recruit subspecialists or doctors to practice in rural and impoverished urban areas. According to the Agency for Healthcare Research and Quality (AHRQ), physician turnover can affect health care quality because it deprives patients of caregivers who know them well and who can serve as their advocates.

Measure Definition

The *Practitioner Turnover* measure shows the percentage of PCPs affiliated with the health plan as of December 2004 who *were not* affiliated with the health plan as of December 2005.

Notes

For this measure, lower rates indicate better performance; therefore, above-average performance is based on achieving lower–than-average provider turnover rates.

This measure is affected by health plan mergers, acquisitions, and other marketplace changes. A health plan that has undergone a recent organizational change is likely to have a higher-than-usual turnover rate. The higher rate is usually an adjustment to change and tends to stabilize in subsequent years.

Results *(see Table 107)*

- From 2004–2006, the Maryland HMO/POS average decreased by 1 percentage point to 6%, showing an overall improvement in performance.
- Four of the seven plans experienced significant decreases in their practitioner turnover rate, indicating an improvement in stability, while one plan experienced a significant increase, and two plans saw no statistically significant change in rate of practitioner turnover.
- In 2006, practitioner turnover rates ranged from 2%–9%, with three plans receiving above-average scores for their low rate of turnover and four plans receiving below-average scores.

Table 107

Practioner Turnover PCP, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2004	2005	2006	Change 2004-2006	2004	2005	2006
Maryland HMO/POS Average	**7%**	**9%**	**6%**	**-1%**			
Aetna	5%	5%	4%	⇔	★★★	★★★	★★★
BlueChoice	6%	5%	8%	🡅	★★★	★★★	★
CIGNA	6%	6%	3%	🡇	★★★	★★★	★★★
Coventry	6%	6%	2%	🡇	★★★	★★★	★★★
Kaiser Permanente	8%	31%	9%	⇔	★★	★	★
M.D. IPA	10%	6%	7%	🡇	★	★★★	★
OCI	10%	6%	7%	🡇	★	★★★	★

Legend

Change 2004–2006

- 🡅 Plan *practitioner turnover* rate increased significantly from 2004 to 2006.
- ⇔ Plan *practitioner turnover* rate *did not* change significantly from 2004 to 2006.
- 🡇 Plan *practitioner turnover* rate decreased significantly from 2004 to 2006.

Relative Rates

- ★★★ = Plan performed significantly better than the Maryland HMO/POS average.
- ★★ = Plan performed equivalent to the Maryland HMO/POS average.
- ★ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- "Change 2004–2006" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Since a higher rate is worse for this measure, the relative rate category has been reversed (i.e., a lower-than-average turnover rate is indicated by ★★★.

NEW MEASURES

NEW MEASURES

Overview

This section contains five measures that were added to HEDIS 2006 and that MHCC required Maryland commercial HMOs to report in 2006. These measures are part of the *Effectiveness of Care* and *Use of Service* domains, and they address management of chronic conditions and medication treatment.

New Measures

- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis
- Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication
- Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Annual Monitoring for Patients on Persistent Medication
- Antibiotic Utilization

Note

Since these are first-year measures, plan-specific rates for these measures are not reported. Instead, this section reports the average rate only. Results will be used for further evaluation and to determine whether there is a need to adjust the specifications for these measures.

DISEASE MODIFYING ANTI-RHEUMATIC THERAPY IN RHEUMATOID ARTHRITIS

Background

Rheumatoid arthritis (RA) is a chronic autoimmune disorder often characterized by progressive joint destruction and multisystem involvement (Hochberg and Spector, 1990). Unlike osteoarthritis, RA is an inflammatory condition, that affects approximately 2.5 million Americans (McDuffie, 1985; Alarcon, 1995), 75% of whom are women. There is no cure; consequently, the goal of treatment is to slow the progression of disease and prevent joint destruction, relieve pain, and maintain functional capacity.

Pharmacological treatment has three divisions: disease-modifying anti-rheumatic drugs (DMARDs), anti-inflammatory agents, and analgesics. DMARDs are used to slow progression of the disease and to produce remission. Early DMARD treatment for RA within three to six months after onset greatly decreases long-term disability status and improvement in health-related quality of life (Pincus, O'Dell, and Kremer, 1999).

Measure Definition

The *Disease Modifying Anti-Rheumatic Therapy in Rheumatoid Arthritis* measure assesses whether patients diagnosed with RA have been prescribed a DMARD.

Results

On average, 80% of members in Maryland plans diagnosed with RA received a DMARD during 2005.

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER (ADHD) MEDICATION

Background

Attention deficit/hyperactivity disorder (ADHD) is the most commonly treated childhood neurobehavioral disorder. It is found in about 3%–6% of school-aged children. At least 10% of behavioral problems seen in general pediatric settings are due to the disorder (Goldman, Genel, Bezman, and Slanetz, 1998).

Given the high prevalence of ADHD among school-aged children, primary care clinicians will encounter children with ADHD in their practices regularly and should have a strategy for diagnosing and long-term management of this condition (American Academy of Pediatrics, 2001). A recent nationwide study showed that only 25% of patients had a follow-up visit with their primary care practitioner within the thirty days following the first ADHD prescription.

Measure Definition

The *Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measure produces two rates that indicate follow-up care for children prescribed an ADHD medication.

1. **Initiation Phase Management:** The percentage of members ages 6–12 years as of the Index Prescription Episode Start Date who had an ambulatory prescription dispensed for ADHD medication and one follow-up visit with a non-mental health or mental health practitioner with prescriptive authority during the 30-day Initiation Phase.

2. **Continuation and Maintenance (C&M) Phase:** The percentage of members ages 6–12 years as of the Index Prescription Episode Start Date who had an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and had at least two additional follow-up visits with a non-mental health or mental health practitioner within nine months after the Initiation Phase ended. (The C&M Phase spans from 31 days to 300 days [a total of nine months] after the Index Prescription Episode Start Date.) *This is a subset of the Initiation Phase measure.*

Results

On average, 31% of members in Maryland plans, had an ambulatory prescription and one follow-up visit during the 30-day initiation phase, while 91% of members who were compliant for the *Initiation Phase* remained on the medication for at least 210 days and had at least two additional follow-up visits within nine months after the initiation phase ended, during 2005.

INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS

Background

Acute bronchitis, commonly known as a chest cold, is an acute respiratory infection, with a normal chest x-ray, that is manifested by cough, with or without phlegm production, that lasts for up to three weeks (Braman, 2006). Each year, about 5% of adults in the United States report an episode of acute bronchitis, with 90% seeking treatment. Fewer than 10% of cases are bacterial (Gonzales et al., 2001; Braman, 2006), suggesting that antibiotic treatment is not a warranted for this primarily viral condition.

Antibiotics are commonly misused and overused for a number of viral respiratory conditions where antibiotic treatment is not effective (Gonzales et al., 2001). About 80% of antibiotics prescribed for acute respiratory infections in adults are unnecessary, according to CDC prevention guidelines (Scott et al., 2001). In 2002, antibiotics were prescribed in 49% of United States adult acute bronchitis cases, despite the typical viral origin (Roumie et al., 2005).

Measure Definition

The *Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis* measure shows the percentage of healthy adults ages 18–64 years with a diagnosis of acute bronchitis who were dispensed an antibiotic prescription on or three days after the episode date. This measure assesses whether antibiotics were inappropriately prescribed for healthy adults with bronchitis.

Antibiotics are not indicated in clinical guidelines for the treatment of adults with acute bronchitis who do not have a comorbid illness or other infection for which antibiotics may be appropriate. A lower rate represents better performance.

Results

On average, 72% of members in Maryland HMOs and POS plans diagnosed with acute bronchitis received an antibiotic on or three days after the episode date, during 2005.

USE OF SPIROMETRY TESTING IN THE ASSESSMENT AND DIAGNOSIS OF COPD

Background

Chronic obstructive pulmonary disease (COPD) is a cause of chronic morbidity and mortality throughout the world and in the United States. In 2003, 10.7 million adults in the United States were estimated to have COPD, and many more are thought to remain undiagnosed (Mannino et al., 2002), as more than one-third of the adult population reported respiratory symptoms compatible with symptomatic COPD (Snow, Lascher, and Mottur-Pilson, 2001). COPD defines a group of diseases characterized by airflow obstruction and includes chronic bronchitis and emphysema (Mannino et al., 2002). After heart disease, cancer, and stroke, COPD is the fourth leading cause of death in the United States. It is projected to move into the third place by 2020 (Snow et al., 2001; National Heart Lung and Blood Institute, 2003).

Spirometry is a simple test that measures the total amount and speed at which a person can breathe out air (Global Initiative for Chronic Obstructive Lung Disease, 2005). Both symptomatic and asymptomatic patients suspected of having COPD should have spirometry performed to establish airway limitation and severity (Sutherland and Cherniack, 2004). On an initial doctor visit for COPD assessment, spirometry assessments are performed before and after bronchodilation to confirm the presence and reversibility of airflow obstruction. Spirometry is important because COPD can be present without physical impairment or symptoms. To initialize appropriate treatment, it is essential to confirm the presence and reversibility of airflow obstruction and to distinguish COPD from asthma (Global Initiative for Chronic Obstructive Lung Disease, 2005; Sutherland, 2004).

Measure Definition

The *Use of Spirometry in the Assessment and Diagnosis of COPD* measure shows the percentage of members age 40 and older during the measurement year with a new diagnosis of COPD who received spirometry testing to confirm this diagnosis.

Results

On average, 34% of members in Maryland plans age 40 and older, who were diagnosed with COPD, received spirometry testing, during 2005.

ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

Background

Certain medications pose a concern for patient safety, and thus are associated with increased risk of harm from drug side-effects and drug toxicity (Classen, 2003). The intent of this measure is consistent with the challenge to develop preventable, drug-related morbidity outcome indicators that could be used to screen population databases (i.e., managed care claims systems) to focus on issues of safety within the United States health care system (MacKinnon & Hepler, 2002).

Patient safety is one of the six domains of health care quality defined in the Institute of Medicine's report *Crossing the Quality Chasm* (2001). The report suggests that better integration of health information technology into healthcare delivery could improve safety and effectiveness of care. For example, automated order entries help in reducing errors in prescribing drugs; reminder systems help providers adhere to clinical guidelines; and use of information technology in disease management improves quality. Health information technology is a promising avenue for better monitoring of patients' medications. Performance measures that address patient safety provide meaningful and useful information to clinicians, health care administrators, and patients, as well, because they facilitate the delivery of quality health care and in the end, save lives.

Measure Definition

The *Annual Monitoring for Patients on Persistent Medications* measure shows the percentage of members age 18 years and older who are on persistent medications and who received annual monitoring for the following five drugs.

- Angiotensin-converting enzyme (ACE) inhibitors/Angiotensin II receptor blockers (ARB)
- Digoxins
- Diuretics
- Anticonvulsants
- Statins

The measure produces a combined rate and separate rates for each drug.

Results

On average, in 2005, the percentages of members on persistent medications in Maryland plans who received annual monitoring for their drugs are as follows.

Drug	Percentage of Members Receiving Annual Monitoring
Total (all drugs)	73%
ACE	74%
Digoxins	72%
Diuretics	73%
Anticonvulsants	56%
Statins	72%

ANTIBIOTIC UTILIZATION

Background

With the widespread availability of antibiotics, misuse of this group of drugs is becoming a growing problem. Data has shown that providers often prescribe antibiotics when they are not necessary, and often for common illnesses such as upper respiratory infections, thus facilitating bacterial resistance to the antibiotics that are available currently. As resistance increases, there is a greater challenge in trying to cure bacterial illnesses with the antibiotic medications that are currently available. There is a need to reduce overall antibiotic utilization and improve appropriate antibiotic use.

CDC, in response to this problem, created a national campaign to raise awareness on appropriate antibiotic use. This campaign, called *Get Smart: Know When Antibiotics Work*, aims to.

1. promote adherence to appropriate prescribing guidelines among providers;
2. decrease demand for antibiotics for viral upper respiratory infections among healthy adults and parents of young children; and
3. increase adherence to prescribed antibiotics for upper respiratory infections (CDC, 2006).

The *Antibiotic Utilization* measure provides very useful information for understanding how drug utilization and selection in managed care may relate to antibiotic drug resistance.

Measure Definition

The *Antibiotic Utilization* measure summarizes data on outpatient utilization of antibiotic prescriptions, including the following.

- Total number of antibiotic prescriptions
- Average number of antibiotic prescriptions per member per year (PMPY)
- Total days supplied for all antibiotic prescriptions
- Average number of days supplied per antibiotic prescription
- Total number of prescriptions PMPY for antibiotics of concern
- Average number of prescriptions PMPY for antibiotics of concern
- Average number of antibiotics PMPY reported by drug class
    - for selected “antibiotics of concern”
    - for all other antibiotics
- Percentage of antibiotics of concern of total antibiotic prescriptions
- During the measurement year, stratified by age and gender and reported for each product

Results

On average, Maryland plans gave 247,965 antibiotic prescriptions, which translates into 0.89 prescriptions annually per member per year.

EXTERNAL ACCREDITATION AND FINANCIAL RATINGS

EXTERNAL ACCREDITATION & FINANCIAL RATINGS

Overview

Accreditation is another way of assessing health plan quality; it is an independent, external assessment of health plan quality by a review organization. The National Committee for Quality Assurance (NCQA) and the American Accreditation Healthcare Commission (URAC) accredit the health plans and managed behavioral healthcare organizations (MBHO) in this report.

Each health care organization (health plans and MBHOs) in this report has voluntarily obtained accreditation through NCQA or URAC, or both. In Maryland, accreditation is not required for health plans or MBHOs.

An assessment of financial strength provides a glimpse into a health plan's ability to manage its business operations. Financial ratings in this report were obtained from AM Best, an independent organization that assesses the ability of companies to meet their financial obligations.

HEALTH PLAN ACCREDITATION

Table 108 identifies the accreditation status of each Maryland health plan and identifies the accrediting organization.

Table 108: Health Plan Accreditation Status

Health Plan	Accreditation*		
	Organization	Status	Expiration Date
Aetna	NCQA	Excellent	01/08
BlueChoice	NCQA	Excellent	12/07
CIGNA	NCQA	Excellent	10/06
Coventry	URAC	Full Accreditation	06/07
Kaiser Permanente	NCQA	Excellent	06/07
M.D. IPA	NCQA	Excellent	03/09
OCI	NCQA	Excellent	03/09

*Accreditation status as of August 2006.

NCQA Health Plan Accreditation

NCQA Accreditation evaluates how well a health plan manages its delivery system—physicians, hospitals, other providers, and administrative services—to continuously improve health care for its members. A team of physicians and managed care experts conducts onsite and offsite evaluations. The team reviews grievance procedures, physician evaluation and care management processes, preventive health efforts, medical record keeping, quality improvement, and performance on key aspects of clinical care, such as immunization rates. In 2006, NCQA's Accreditation program required plans to report performance results for 19 clinical care measures.

A national Review Oversight Committee (ROC) of physicians analyzes the team's findings and assigns an accreditation level based on a plan's performance on selected HEDIS measure, relative to NCQA standards and to other plans. The standards and performance measures that make up NCQA's Accreditation program fall into the following categories: Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living With Illness.

NCQA Accreditation Levels

NCQA assigns one of five possible accreditation levels based on a plan's performance.

- ***Excellent:*** Highest accreditation status, awarded to plans demonstrating levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS results in the highest range of national or regional performance.
- ***Commendable:*** Awarded to plans demonstrating levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement.
- ***Accredited:*** Awarded to health plans meeting most of NCQA's basic requirements for consumer protection and quality improvement.
- ***Provisional:*** Awarded to health plans meeting some, but not all, of NCQA's basic requirements for consumer protection and quality improvement.
- ***Denied:*** Indicates that a health plan did not meet NCQA's requirements.

Pharmacy Management Standards

Maryland plans accredited by NCQA have met NCQA standards for pharmaceutical management, including formulary development. To help ensure that plan drug formularies are fair and valid, formulary policies are reviewed under the pharmaceutical management standards for MCOs that choose to be accredited by NCQA. NCQA standards require a plan's formulary to meet the following criteria.

- The formulary is based on sound clinical evidence.
- There is annual review of the formulary, with updates at least annually.
- There is involvement of appropriate, actively practicing practitioners, including pharmacists, in the development and updating of the formulary.
- There is a policy of giving practitioners a copy of the formulary and notifying them of changes.
- There are policies that consider medically necessary exceptions to the formulary.

The following health plans are accredited by NCQA and have met the pharmaceutical management standards described above: Aetna, BlueChoice, CIGNA, Kaiser Permanente, M.D. IPA, and OCI.

URAC Health Plan Accreditation

URAC's Health Plan Accreditation standards provide a comprehensive assessment of health plan performance, and apply to health care systems such as HMOs and fully integrated PPOs that provide a full range of health care services. Standards include key quality benchmarks for network management, provider credentialing, utilization and quality management, improvement, and consumer protection.

Organizations applying for accreditation participate in a review process involving several phases. The initial phase consists of completing the application forms and supplying supporting documentation. The remaining phases of the accreditation process cover a period of approximately three to six months. These phases include the following.

- ***Desktop Review:*** During the review process, the reviewer conducts an analysis of the applicant's documentation in relation to URAC standards.
- ***Onsite Review:*** The accreditation review team conducts an onsite review after completing the desktop review to verify compliance with the standards.
- ***Committee Review:*** The last phase of review leading to a recommendation regarding the application involves examination by two URAC committees that comprise professionals from health care and other industry experts.
- ***Conditions of Accreditation:*** Organizations awarded full accreditation must remain compliant with URAC standards during the two-year accreditation cycle.

URAC Accreditation Levels

URAC assigns health plans one of three possible accreditation levels based on a plan's performance.

- ***Full:*** Awarded to organizations that successfully meet all requirements. Full Accreditation is for two years. An accreditation certificate is issued to each company site that participates in the accreditation review.
- ***Conditional:*** Awarded to organizations that have appropriate documentation but did not completely implement certain policies or procedures before achieving full compliance. URAC requires organizations with Conditional Accreditation to follow a plan to demonstrate full compliance and move to Full Accreditation status within six months.
- ***Provisional:*** Awarded to organizations that complied with all standards but were not in operation long enough (less than six months) at the time of the onsite review to demonstrate full compliance. URAC requires organizations with Provisional Accreditation to demonstrate full compliance of standards to meet Full Accreditation status.

Organizations unable to meet URAC standards may be placed on corrective action status, may be denied accreditation, or may withdraw.

MBHO ACCREDITATION

Like health plans, MBHOs can apply for voluntary accreditation. Accreditation indicates that the MBHO has met the quality standards set by the accrediting organization. Maryland plans in this report have elected to become accredited by NCQA or URAC, or both.

Table 109 shows which plans use MBHOs to cover some or all of their members. The table also indicates each MBHO's accreditation status, the accrediting organization, and when current accreditation expires. Three plans provide behavioral health services through their own provider network. Behavioral health services for these plans are not accredited separately from the health plan's accreditation.

Table 109: MBHO Accreditation Status and Behavioral Health Benefit

Health Plan	MBHO	Accrediting Body*	Accreditation Status: Expiration Date	% of Members With Behavioral Health Benefit
Aetna	Aetna Behavioral Health	N/A	N/A	100
BlueChoice	Magellan Behavioral Health—Mid-Atlantic Care Management Center	NCQA URAC	Full: Expires 5/09 Full: Expires 6/07	100
CIGNA	CIGNA Behavioral Health—Maryland	NCQA URAC	Full: Expires 1/07 Full: Expires 11/06	81.7
Coventry	United Behavioral Health—Atlanta Regional Care Center	NCQA URAC	Full: Expires 12/07 Full: Expires 2/07	96.3
Kaiser Permanente**	Plan Network Providers	NA	NA	100
	APS Healthcare	URAC	Full: Expires 1/08	
M.D. IPA	Plan Network Providers	NA	NA	85.9
OCI	Plan Network Providers	NA	NA	99.5

* Accreditation is voluntary. Accreditation Status as of August 2006.

** During 2006, Kaiser Permanente will transition to an in-house network of behavioral health providers for members, except in the Baltimore area. For further details, contact Kaiser Permanente.

NCQA—National Committee for Quality Assurance
URAC—URAC/American Accreditation Healthcare Commission
For the most current information on accreditation status, visit www.ncqa.org and www.urac.org.

NCQA MBHO Accreditation

NCQA's MCO and MBHO Accreditation Programs are closely aligned with nearly identical sets of standards that apply to both types of organizations. Both programs seek to promote access to behavioral healthcare and coordination between medical and behavioral health professionals.

The MBHO accreditation program requires an MBHO to annually monitor and evaluate at least two preventive behavioral health screening and educational interventions offered to its covered population. The categories of preventive interventions listed in the standard are adapted from the Institute of Medicine's *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*, 1994. This publication lists a number of illustrative preventive interventions for the various age and population categories.

URAC MBHO Accreditation

Like other integrated health care delivery systems, MBHOs may choose to undergo a full review of their operations or have individual components reviewed for accreditation. URAC's Health Plan Standards program assesses an organization and assigns an accreditation level based on performance regarding defined standards. This process consists of the same multi-phase review described in the previous section, *Health Plan Accreditation.* A range of accreditation programs is available through URAC, permitting review of a segment of the operations. The Health Utilization Management Standards are an example of an accreditation module that MCOs (such as MBHOs) select to demonstrate they have the appropriate structures and procedures to promote quality care when making medical necessity determinations.

A.M. BEST'S FINANCIAL RATINGS

A.M. Best's financial strength rating provides an independent opinion on a health insurance organization's ability to meet obligations to its membership through an evaluation of its balance-sheet strength, operating performance, and business profile.

Table 110 below shows the A.M. Best financial rating of each Maryland health plan.

Table 110: Health Plan Financial Rating

Health Plan	A.M. Best Financial Rating*
Aetna	A/ Excellent (A.M. Best ID# 68550)
BlueChoice	B+/ Very Good/ pd (A.M. Best ID# 68605)
CIGNA	A-/ Excellent (A.M. Best ID# 68871)
Coventry	B+/ Very Good (A.M. Best ID# 68687)
Kaiser Permanente	B++/ Very Good pd (A.M. Best ID# 68551)
M.D. IPA	A/ Excellent (A.M. Best ID# 68606)
OCI	A/ Excellent (A.M. Best ID# 68764)

*A.M. Best Financial Rating as of August 2006.
Ratings Modifiers: pd Public Data
For the most current information on financial ratings, visit www.ambest.com

A.M. Best Analysis

At the HMO's or insurance company's request, A.M. Best's analysts review detailed financial statements, interview senior management, and analyze data and information, leading to an assignment of a financial strength rating following a committee review process. All health insurance companies are formally evaluated once every 12 months, and are subject to review following a significant event (e.g., catastrophe; unexpected changes in earnings, capital, management, or ownership).

Analysis may also be conducted on a non-interactive basis, where A.M. Best assigns a rating after a comprehensive review of regulatory filings, publicly available data, and other public information. This type of rating is denoted as pd (public data).

The Best's Rating scale is composed of 16 individual ratings, grouped into 10 categories. There are 3 **Secure** categories: Superior, Excellent, and Very Good; and 7 **Vulnerable** categories: Fair, Marginal, Weak, Poor, Under Regulatory Supervision, In Liquidation, and Rating Suspended. A rating modifier can be assigned to indicate that a Best's Rating may be subject to near-term change (under review) and that a company did not subscribe to Best's interactive rating process (pd).

Secure ratings indicate that an insurer has a strong or good ability to meet its obligations to members and policyholders and that it maintains a level of financial strength that can withstand unfavorable changes in the business, economic, or regulatory environment. Vulnerable ratings tend to present progressively higher risks. Public data ratings incorporate analysis of balance sheet strength, operating performance, and business profile; however, analysis does not generally involve interaction with company management.

For non-rated (NR) companies, a condition exists that makes it difficult for A.M. Best to develop an opinion on the company's balance sheet strength and operating performance. Generally, these companies do not qualify for a Best's Rating because of limited financial information, small level of surplus, lack of sufficient operating experience, or due to their dormant or run-off status. Unrated companies are assigned to one of five NR categories.

Definitions of Best's Ratings and NR Categories

Secure Best's Ratings

***A++ and A+ (Superior)*:** Assigned to companies that have, in A.M. Best's opinion, a superior ability to meet their ongoing obligations to policyholders.

A and A- (Excellent): Assigned to companies that have, in A.M. Best's opinion, an excellent ability to meet their ongoing obligations to policyholders.

B++ and B+ (Very Good): Assigned to companies that have, in A.M. Best's opinion, a good ability to meet their ongoing obligations to policyholders.

Vulnerable Best's Ratings

B and B- (Fair): Assigned to companies that have, in A.M. Best's opinion, a fair ability to meet their current obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.

C++ and C+ (Marginal): Assigned to companies that have, in A.M. Best's opinion, a marginal ability to meet their current obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.

C and C- (Weak): Assigned to companies that have, in A.M. Best's opinion, a weak ability to meet their current obligations to policyholders, but are financially very vulnerable to adverse changes in underwriting and economic conditions.

D (Poor): Assigned to companies that may not have, in A.M. Best's opinion, an ability to meet their current obligations to policyholders and are financially extremely vulnerable to adverse changes in underwriting and economic conditions.

E (Under Regulatory Supervision): Assigned to companies (and possibly their subsidiaries/affiliates) placed by an insurance regulatory authority under a significant form of supervision, control, or restraint, whereby they are no longer allowed to conduct normal ongoing insurance operations. This would include conservatorship or rehabilitation, but does not include liquidation. It may also be assigned to companies issued cease and desist orders by regulators outside their home state or country.

F (In Liquidation): Assigned to companies that have been placed under an order of liquidation by a court of law or whose owners have voluntarily agreed to liquidate the company.

Note: *Companies that voluntarily liquidate or dissolve their charters are generally not insolvent.*

S (Rating Suspended): Assigned to rated companies that have experienced sudden and significant events affecting their balance sheet strength or operating performance whose rating implications cannot be evaluated due to a lack of timely or adequate information

APPENDIX A
HEALTH PLAN PERFORMANCE BY MEASURE

HEALTH PLAN PERFORMANCE BY MEASURE

This appendix contains plan results sorted by plan's rates for selected measures to show which plans performed best in each category of care. The measures were based on the eligible measures that were included in the above-average scores calculation described in the *Summary of Performance* section.

Effectiveness of Care
Plan Performance by Measure

Childhood Immunization Status Combination 2 2006 Results		
Maryland HMO/POS Average	**81%**	
Kaiser Permanente	86%	★★★★
CIGNA	85%	★★★
Aetna	84%	★★★
BlueChoice	83%	★★
Coventry	77%	★
OCI	76%	★
M.D. IPA	73%	★

Adolescent Immunization Status Combination 2 2006 Results		
Maryland HMO/POS Average	**60%**	
Kaiser Permanente	81%	★★★★
Aetna	62%	★★
BlueChoice	61%	★★
Coventry	58%	★★
CIGNA	55%	★
M.D. IPA	54%	★
OCI	47%	★

Appropriate Testing for Children with Pharyngitis, 2006 Results		
Maryland HMO/POS Average	**74%**	
Kaiser Permanente	94%	★★★
CIGNA	76%	★★★
BlueChoice	76%	★★★
Aetna	71%	★
M.D. IPA	68%	★
OCI	67%	★
Coventry	65%	★

Appropriate Treatment for Children with Upper Respiratory Infection, 2006 Results		
Maryland HMO/POS Average	**89%**	
M.D. IPA	95%	★★★
OCI	94%	★★★
BlueChoice	94%	★★★
Kaiser Permanente	91%	★★★
CIGNA	85%	★
Aetna	84%	★
Coventry	77%	★

Chlamydia Screening Total (Ages 16-25) 2006 Results		
Maryland HMO/POS Average	**43%**	
Kaiser Permanente	76%	★★★★
Aetna	41%	★
M.D. IPA	41%	★
Coventry	39%	★
OCI	37%	★
BlueChoice	35%	★
CIGNA	35%	★

Controlling High Blood Pressure 2006 Results		
Maryland HMO/POS Average	**73%**	
CIGNA	81%	★★★★
Kaiser Permanente	77%	★★
M.D. IPA	76%	★★
Aetna	71%	★★
OCI	71%	★★
BlueChoice	70%	★★
Coventry	65%	★

Effectiveness of Care
Plan Performance by Measure

Beta-Blocker Treatment After a Heart Attack 2006 Results		
Maryland HMO/POS Average	**97%**	
Kaiser Permanente	100%	★★★
CIGNA	99%	★★★
Coventry	99%	★★
Aetna	98%	★★
BlueChoice	98%	★★
M.D. IPA	94%	★★
OCI	90%	★

Persistence of Beta-Blocker Treatment After a Heart Attack, 2006 Results		
Maryland HMO/POS Average	**68%**	
Kaiser Permanente	80%	★★★
Coventry	75%	★★
M.D. IPA	68%	★★
OCI	68%	★★
CIGNA	68%	★★
Aetna	64%	★★
BlueChoice	56%	★

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Testing, 2006 Results		
Maryland HMO/POS Average	**85%**	
CIGNA	90%	★★★
Aetna	86%	★★
Kaiser Permanente	85%	★★
M.D. IPA	85%	★★
Coventry	84%	★★
BlueChoice	83%	★★
OCI	83%	★★

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Control, 2006 Results		
Maryland HMO/POS Average	**71%**	
Kaiser Permanente	77%	★★★
CIGNA	73%	★★
M.D. IPA	73%	★★
BlueChoice	70%	★★
OCI	70%	★★
Aetna	67%	★★
Coventry	66%	★

Comprehensive Diabetes Care, Cholesterol (LDL-C) Testing, 2006 Results		
Maryland HMO/POS Average	**91%**	
CIGNA	93%	★★
M.D. IPA	91%	★★
Coventry	91%	★★
BlueChoice	91%	★★
Kaiser Permanente	91%	★★
Aetna	90%	★★
OCI	90%	★★

Comprehensive Diabetes Care, Cholesterol (LDL-C) <100mg/dL Control, 2006 Results		
Maryland HMO/POS Average	**49%**	
Kaiser Permanente	55%	★★★
BlueChoice	54%	★★★
M.D. IPA	52%	★★
OCI	50%	★★
CIGNA	47%	★★
Aetna	43%	★
Coventry	40%	★

Effectiveness of Care
Plan Performance by Measure

Comprehensive Diabetes Care, Cholesterol (LDL-C) <130mg/dL Control, 2006 Results		
Maryland HMO/POS Average	**72%**	
Kaiser Permanente	77%	★★★
M.D. IPA	75%	★★
OCI	74%	★★
CIGNA	72%	★★
BlueChoice	72%	★★
Aetna	70%	★★
Coventry	63%	★

Comprehensive Diabetes Care, Eye Exams 2006 Results		
Maryland HMO/POS Average	**57%**	
M.D. IPA	67%	★★★
Kaiser Permanente	66%	★★★★
BlueChoice	55%	★★
Coventry	55%	★★
Aetna	54%	★★
CIGNA	53%	★
OCI	53%	★

Comprehensive Diabetes Care, Monitoring Diabetic Nephropathy, 2006 Results		
Maryland HMO/POS Average	**56%**	
Kaiser Permanente	70%	★★★★
M.D. IPA	56%	★★
Coventry	55%	★★
CIGNA	54%	★★
OCI	53%	★★
BlueChoice	52%	★★
Aetna	51%	★

Comprehensive Diabetes Care MHCC- Specific Combination Rating, 2006 Results		
Maryland HMO/POS Average	**22%**	
Kaiser Permanente	43%	★★★
CIGNA	21%	★★
BlueChoice	19%	★★
M.D. IPA	19%	★★
Aetna	18%	★★
OCI	16%	★
Coventry	15%	★

Use of Appropriate Medications for People With Asthma (Ages 5-17 Years), 2006 Results		
Maryland HMO/POS Average	**94%**	
Kaiser Permanente	96%	★★★
Coventry	96%	★★
BlueChoice	95%	★★
CIGNA	95%	★★
OCI	94%	★★
M.D. IPA	93%	★★
Aetna	90%	★

Use of Appropriate Medications for People With Asthma (Ages 18-56 Years), 2006 Results		
Maryland HMO/POS Average	**93%**	
BlueChoice	98%	★★★
Kaiser Permanente	97%	★★★
Coventry	93%	★★
M.D. IPA	92%	★★
OCI	91%	★
CIGNA	90%	★
Aetna	88%	★

Effectiveness of Care
Plan Performance by Measure

Flu Shots for Adults Ages 50-64 2006 Results		
Maryland HMO/POS Average	**36%**	
Kaiser Permanente	45%	★★★
M.D. IPA	41%	★★
Aetna	37%	★★
BlueChoice	35%	★★
OCI	33%	★★
Coventry	33%	★★
CIGNA	29%	★

Colorectal Cancer Screening 2006 Results		
Maryland HMO/POS Average	**55%**	
CIGNA	60%	★★★
M.D. IPA	59%	★★★★
Coventry	56%	★★
BlueChoice	54%	★★
Kaiser Permanente	53%	★
OCI	53%	★
Aetna	52%	★

Breast Cancer Screening 2006 Results		
Maryland HMO/POS Average	**71%**	
Kaiser Permanente	78%	★★★
M.D. IPA	73%	★★★
Coventry	73%	★★★★
BlueChoice	71%	★
CIGNA	69%	★
OCI	68%	★
Aetna	68%	★

Cervical Cancer Screening 2006 Results		
Maryland HMO/POS Average	**83%**	
Aetna	85%	★★
BlueChoice	84%	★★
CIGNA	84%	★★
M.D. IPA	83%	★★
Coventry	82%	★★
Kaiser Permanente	81%	★
OCI	81%	★★

Advising Smokers to Quit 2006 Results		
Maryland HMO/POS Average	**73%**	
Coventry	76%	★★
Kaiser Permanente	76%	★★
M.D. IPA	76%	★★
BlueChoice	75%	★★
CIGNA	71%	★★
OCI	67%	★★
Aetna	67%	★★

Discussing Smoking Cessation Medications 2006 Results		
Maryland HMO/POS Average	**37%**	
BlueChoice	44%	★★
M.D. IPA	41%	★★
Coventry	37%	★★
Aetna	37%	★★
OCI	36%	★★
Kaiser Permanente	35%	★★
CIGNA	33%	★★

Effectiveness of Care
Plan Performance by Measure

Discussing Smoking Cessation Strategies 2006 Results		
Maryland HMO/POS Average	**37%**	
Kaiser Permanente	43%	★★
M.D. IPA	40%	★★
BlueChoice	39%	★★
Coventry	39%	★★
CIGNA	35%	★★
OCI	33%	★★
Aetna	31%	★★

Access/Availability of Care
Plan Performance by Measure

Adults' Access to Preventive/Ambulatory Health Services (Ages 20-64), 2006 Results		
Maryland HMO/POS Average	**94%**	
Coventry	95%	★★★
Kaiser Permanente	95%	★★★
M.D. IPA	94%	★★★
BlueChoice	93%	★
CIGNA	93%	★
OCI	93%	★
Aetna	92%	★

Children's Access to Primary Care Practitioners (12- 24 Months), 2006 Results		
Maryland HMO/POS Average	**97%**	
BlueChoice	98%	★★★
Aetna	98%	★★
CIGNA	97%	★★
M.D. IPA	97%	★★
Kaiser Permanente	97%	★★
Coventry	97%	★★
OCI	97%	★★

Children's Access to Primary Care Practitioners (25 Months-6 Years), 2006 Results		
Maryland HMO/POS Average	**91%**	
Coventry	93%	★★★
BlueChoice	92%	★★★
Aetna	91%	★★
CIGNA	91%	★★
Kaiser Permanente	90%	★
M.D. IPA	89%	★
OCI	89%	★

Children's Access to Primary Care Practitioners (7-11 years), 2006 Results		
Maryland HMO/POS Average	**90%**	
Coventry	92%	★★★
BlueChoice	92%	★★★
Kaiser Permanente	90%	★★★
Aetna	89%	★
M.D. IPA	88%	★
CIGNA	88%	★
OCI	87%	★

Adolescents' Access to Primary Care Practitioners (12-19 years), 2006 Results		
Maryland HMO/POS Average	**86%**	
Coventry	88%	★★★
Kaiser Permanente	88%	★★★
BlueChoice	88%	★★★
CIGNA	86%	★★
M.D. IPA	84%	★
OCI	83%	★
Aetna	83%	★

Well-Child Visits for Infants and Children Composite, 2006 Results		
Maryland HMO/POS Average	**72%**	
M.D. IPA	77%	★★★
Coventry	77%	★★★★
CIGNA	75%	★★★★
BlueChoice	73%	★★★
OCI	72%	★★
Aetna	67%	★
Kaiser Permanente	66%	★

Access/Availability of Care
Plan Performance by Measure

Adolescent Well-Care Visits 2006 Results		
Maryland HMO/POS Average	**39%**	
BlueChoice	42%	★★★★
Coventry	40%	★★★★
Aetna	39%	★★★
M.D. IPA	38%	★
OCI	38%	★
CIGNA	37%	★
Kaiser Permanente	37%	★

Prenatal and Postpartum Care, Prenatal 2006 Results		
Maryland HMO/POS Average	**93%**	
CIGNA	98%	★★★
BlueChoice	96%	★★★
Aetna	95%	★★★
Kaiser Permanente	94%	★★
Coventry	92%	★★
M.D. IPA	88%	★
OCI	87%	★

Prenatal and Postpartum Care, Postpartum 2006 Results		
Maryland HMO/POS Average	**83%**	
CIGNA	88%	★★★
Kaiser Permanente	87%	★★★
Aetna	82%	★★
Coventry	82%	★★
BlueChoice	82%	★★
M.D. IPA	80%	★★
OCI	78%	★

Satisfaction with the Experience of Care
Plan Performance by Measure

Rating of Health Plan (Rating 9-10) 2006 Results		
Maryland HMO/POS Average	**38%**	
BlueChoice	43%	★★★
OCI	41%	★★
Coventry	39%	★★
M.D. IPA	39%	★★
Kaiser Permanente	37%	★★
Aetna	36%	★★
CIGNA	31%	★

Recommending Plan to Friends/Family (Definitely Yes), 2006 Results		
Maryland HMO/POS Average	**40%**	
BlueChoice	43%	★★
M.D. IPA	43%	★★
Kaiser Permanente	42%	★★
OCI	42%	★★
Aetna	39%	★★
Coventry	38%	★★
CIGNA	31%	★

Few Consumer Complaints (No, Did Not Complain) 2006 Results		
Maryland HMO/POS Average	**85%**	
Kaiser Permanente	89%	★★★
BlueChoice	86%	★★
OCI	86%	★★
M.D. IPA	86%	★★
CIGNA	85%	★★
Aetna	83%	★★
Coventry	82%	★

Health Plan Customer Service (Not a Problem) 2006 Results		
Maryland HMO/POS Average	**70%**	
M.D. IPA	77%	★★★★
OCI	71%	★★
Kaiser Permanente	70%	★★
Aetna	70%	★★
Coventry	69%	★★
BlueChoice	68%	★★
CIGNA	65%	★

Satisfaction with the Experience of Care
Plan Performance by Measure

Getting Needed Care (Not a Problem) 2006 Results		
Maryland HMO/POS Average	**76%**	
OCI	79%	★★★
Coventry	79%	★★
BlueChoice	77%	★★
CIGNA	77%	★★
M.D. IPA	75%	★★
Aetna	74%	★★
Kaiser Permanente	71%	★

Getting Care Quickly (Always) 2006 Results		
Maryland HMO/POS Average	**41%**	
Coventry	48%	★★★★
BlueChoice	44%	★★
OCI	41%	★★
CIGNA	41%	★★
Aetna	40%	★★
M.D. IPA	38%	★★
Kaiser Permanente	37%	★

How Well Doctors Communicate (Always) 2006 Results		
Maryland HMO/POS Average	**59%**	
BlueChoice	62%	★★
Aetna	61%	★★
Coventry	61%	★★
OCI	60%	★★
CIGNA	59%	★★
M.D. IPA	55%	★
Kaiser Permanente	55%	★

Rating of Health Care (Rating 9-10) 2006 Results		
Maryland HMO/POS Average	**47%**	
BlueChoice	53%	★★★
Coventry	51%	★★
OCI	49%	★★
Aetna	47%	★★
M.D. IPA	45%	★★
CIGNA	44%	★★
Kaiser Permanente	41%	★

Behavioral Healthcare
Plan Performance by Measure

Follow-up After Hospitalization for Mental Illness 7 Days, 2006 Results		
Maryland HMO/POS Average	**58%**	
Kaiser Permanente	67%	★★★
BlueChoice	62%	★★★
OCI	59%	★★
CIGNA	59%	★★
M.D. IPA	57%	★★
Aetna	55%	★★
Coventry	50%	★

Follow-up After Hospitalization for Mental Illness 30 Days, 2006 Results		
Maryland HMO/POS Average	**75%**	
OCI	83%	★★★
M.D. IPA	77%	★★
CIGNA	76%	★★
Kaiser Permanente	75%	★★
BlueChoice	75%	★★
Aetna	72%	★★
Coventry	65%	★

Antidepressant Medication Management Optimal Practitioner Contacts, 2006 Results		
Maryland HMO/POS Average	**20%**	
M.D. IPA	25%	★★★★
CIGNA	23%	★★
OCI	22%	★★★
Aetna	22%	★★
Kaiser Permanente	18%	★
Coventry	18%	★★
BlueChoice	12%	★

Antidepressant Medication Management Effective Acute Phase Treatment, 2006 Results		
Maryland HMO/POS Average	**62%**	
BlueChoice	68%	★★★
Aetna	64%	★★
OCI	62%	★★
Coventry	62%	★★
CIGNA	61%	★★
M.D. IPA	58%	★★
Kaiser Permanente	56%	★

Antidepressant Medication Management Effective Continuation Phase, 2006 Results		
Maryland HMO/POS Average	**44%**	
Aetna	50%	★★★
Coventry	47%	★★
CIGNA	44%	★★
OCI	43%	★★
BlueChoice	41%	★
M.D. IPA	40%	★★
Kaiser Permanente	40%	★

Behavioral Healthcare
Plan Performance by Measure

Initiation of Alcohol and Other Drug Treatment 2006 Results		
Maryland HMO/POS Average	**46%**	
Kaiser Permanente	65%	★★★
CIGNA	48%	★★
Aetna	48%	★★
M.D. IPA	46%	★★
OCI	43%	★
Coventry	38%	★
BlueChoice	31%	★

Initiation of Alcohol and Other Drug Treatment-Engagement, 2006 Results		
Maryland HMO/POS Average	**14%**	
Kaiser Permanente	22%	★★★
BlueChoice	19%	★★★
OCI	15%	★★
Aetna	12%	★
M.D. IPA	10%	★
CIGNA	10%	★
Coventry	10%	★

Health Plan Descriptive Information
Plan Performance by Measure

PCP Board Certification 2006 Results		
Maryland HMO/POS Average	**84%**	
Kaiser Permanente	93%	★★★
CIGNA	88%	★★★
Coventry	84%	★★
Aetna	83%	★★
BlueChoice	82%	★
M.D. IPA	79%	★
OCI	77%	★

OB/GYN Board Certification 2006 Results		
Maryland HMO/POS Average	**79%**	
Kaiser Permanente	89%	★★★
CIGNA	85%	★★★
Aetna	79%	★★
Coventry	77%	★★
BlueChoice	76%	★
M.D. IPA	73%	★
OCI	72%	★

Pediatric Board Certification 2006 Results		
Maryland HMO/POS Average	**78%**	
BlueChoice	83%	★★
Coventry	82%	★★
M.D. IPA	81%	★★
OCI	81%	★★
Kaiser Permanente	79%	★★
CIGNA	72%	★
Aetna	70%	★

Other Board Certification 2006 Results		
Maryland HMO/POS Average	**80%**	
Kaiser Permanente	85%	★★★
Coventry	84%	★★★
CIGNA	82%	★★★
BlueChoice	81%	★★★
M.D. IPA	77%	★
OCI	77%	★
Aetna	74%	★

Health Plan Stability
Plan Performance by Measure

Practioner Turnover PCP 2006 Results		
Maryland HMO/POS Average	**6%**	
Coventry	2%	★★★
CIGNA	3%	★★★
Aetna	4%	★★★
OCI	7%	★
M.D. IPA	7%	★
BlueChoice	8%	★
Kaiser Permanente	9%	★

APPENDIX B
METHODS FOR DATA ANALYSES

METHODS FOR DATA ANALYSES

Methodology to Compare Plan Performance

For each HEDIS measure, CAHPS question, and CAHPS composite, a score is computed for each plan, and the mean value is computed for all of the plans as a group. Each score or mean is expressed as a percentage with higher values representing more favorable performance.

Plan ratings for each measure are based on the difference between the plan score and the unweighted group mean. The statistical significance of each difference is determined by computing a 95% confidence interval (CI) around it. If the lower limit of the CI exceeds zero then the plan score is significantly above the mean. If the upper limit of the CI is less than zero then the plan score is significantly below the mean. Plans with scores significantly above or below the mean at the 95% significance level usually received the highest and lowest designations respectively. All remaining plans received the middle designation.

The specific formula for calculating the CI for each measure is as follows:

For a given HEDIS measure or CAHPS individual question and plan k, let the difference d_k = plan k score – group mean. Then the formula for the 95% CI is $d_k \pm 1.96\sqrt{Var(d_k)}$

where $Var(d_k)$= Variance of d_k is estimated as

$$\frac{P(P-2)}{P^2} * \frac{p_k(1-p_k)}{n_k} + \frac{1}{P^2}\sum_{k=1}^{P}\frac{p_k(1-p_k)}{n_k}$$

and p_k = plan k score
P = total number of plans
n_k = the measure denominator for plan k

For a CAHPS composite, the variance formula is modified by substituting the plan composite global proportion variance ($CGPV_k$) for the $p_k(1-p_k)/n_k$ terms where

$$CGPV_k = \frac{N}{N-1}\sum_{i=1}^{N}\left(\sum_{j=1}^{m}\frac{1}{m}\frac{(x_{ij}-\bar{x}_j)}{n_j}\right)^2$$

and $j = 1,\ldots,m$ questions in the composite measure
$i = 1,\ldots,n_j$ members responding to question j
x_{ij} = response of member i to question j (0 or 1)
$\bar{x}_j$ = plan mean for question j
N = members responding to at least one question in the composite.

Alternatively, the CI formula can be rearranged to compute the test statistic $\frac{d_k^2}{Var(d_k)}$.

For $d_j > 0$, the lower limit of the CI is > 0 if and only if $\frac{d_k^2}{Var(d_k)} > 1.96^2 = 3.84$.

For $d_j < 0$, the upper limit of the CI is < 0 if and only if $\frac{d_k^2}{Var(d_k)} > 1.96^2 = 3.84$.

Comparing Rates Across Years

For determining the statistical significance of the trend in a plan score between 2004 and 2006, first compute the difference in plan scores between the two years. This difference *d* can be written as $p_{2005} - p_{2003}$ where p_{200x} is the plan score for year 200x on a given measure. Then compute a 95% CI around the difference. If the lower limit of the CI is greater than zero then the trend is significantly upward. If the upper limit of the CI is less than zero then the trend is significantly downward.

The formula for the CI around *d* is: $d \pm 1.96\sqrt{Var(d)}$

where $Var(d) = \hat{p}(1-\hat{p})\left(\frac{1}{n_{2004}} + \frac{1}{n_{2006}}\right)$

and $\hat{p} = \frac{p_{2004}n_{2004} + p_{2006}n_{2006}}{n_{2004} + n_{2006}}$

and n_{200x} is the measure denominator for year 200x.

APPENDIX C

METHODOLOGY FOR AUDIT OF HEDIS 2006 RATES FOR MARYLAND HMOS AND POS PLANS

METHODOLOGY FOR AUDIT OF HEDIS 2006 RATES FOR MARYLAND HMOS AND POS PLANS

HEDIS COMPLIANCE AUDIT™

NCQA's HEDIS Compliance Audit is a standardized methodology that enables organizations to make direct comparison of plan rates for HEDIS performance measures. Maryland hired HealthcareData.com, LLC (HDC), an NCQA licensed organization, to conduct a full audit of the Maryland commercial health plans in this report as prescribed by *HEDIS 2006, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*, published by NCQA. In addition, HDC reviewed non-HEDIS data that the MHCC required plans to report in 2006.

A major objective of the audit is to determine the reasonableness and accuracy of how a plan collects and reports data for performance reporting in Maryland. In addition to ensuring that publicly reported rates are accurate and comparable, the audit also satisfies a requirement of NCQA health plan accreditation.

HEDIS is a standardized set of key performance measures designed to allow purchasers and consumers to have the information they need to reliably compare the performance of managed care plans. By using a standardized methodology to collect data and calculate measure results, consumers, government agencies, employers, and health plans can more accurately evaluate and trend plan performance and compare plans. NCQA-Certified HEDIS Compliance auditors focused on two areas in each health plan, specifically: (1) an assessment of overall information system (IS) capabilities; and (2) an evaluation of the plan's ability to comply with HEDIS specifications for individual measures.

Audit Implementation

The audit process itself is divided into three phases: (1) audit preparation; (2) onsite visit; and (3) post-onsite and reporting activities. During these three phases, auditors focused on a number of performance areas, including information practices and control procedures, sampling methods, data integrity, analytic file production, algorithmic compliance with measurement specifications, reporting, and documentation. A detailed description of the well-defined phases of the audit appears in NCQA's *HEDIS 2006, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*.

Phase 1: Audit Preparation

The initial phase consists of various supporting tasks or activities defined by NCQA. Activities performed include the following.

- Provide the Baseline Assessment Tool (BAT) to health plans for completion
- Select mutually agreeable audit dates
- Certify the CAHPS sample frame
- Review the completed BAT
- Select core measures
- Finalize the audit team
- Request source code for measures outside of precertified software
- Develop a detailed agenda for the onsite audit
- Review various vendor operations and processes
- Conduct a previsit conference call to discuss outstanding issues

A key activity critical to the audit's success is each plan's completion of the BAT in a timely manner prior to the onsite visit, followed by a review of the completed tool by auditors and MHCC staff. The BAT is a comprehensive instrument designed by NCQA to collect information from the health plan regarding its structure, information collection and processing (e.g., claim/encounter, medical record review, membership data, provider data), and HEDIS reporting procedures (e.g., measure programming/ determinations, reporting functions).

Auditors also perform the key task of selecting a core set of measures for each plan. The protocol requires the minimum number of measures (13 in each core set) to be distributed across six HEDIS domains. As required, the core set can be expanded based on any finding or issue that surfaces during the onsite audit. Each auditor uses a variety of criteria to select the core set, which includes, but is not limited to, the following.

- Measures revised by NCQA from the prior year
- New measures being reported
- Measures calculated by vendors or outside third parties
- Issues identified from review of the BAT that could impact code development
- Internal processes affecting data collection
- Problems experienced by the plan in prior audits

Auditors use the core set to evaluate all measures within the various HEDIS domains. Findings from their review are then extrapolated to the full set of HEDIS measures to make a final determination of reportability. Only one Maryland plan used an NCQA-Certified software vendor to calculate its measures. All source code associated with the core set measures for the other six plans was reviewed by designated audit staff.

Source-code review for measures in the core set begins during Phase One, with initial review of the source code associated with the CAHPS sample frame programming.

Phase 2: Onsite Visit

During Phase 2 of the compliance audit, auditors conduct in-person interviews and record examination at the office of each plan. The onsite portion comprises a number of critical activities that fall into two broad categories: (1) an assessment of compliance with NCQA's standards for information systems (IS) capabilities; and (2) an evaluation of compliance with HEDIS measure specifications.

(1) IS Standards Assessment: Auditors determine the impact of various IS practices on the HEDIS reporting process. The key to accurate reporting is collecting comprehensive and accurate data. Auditors do not attempt to evaluate the overall effectiveness of the health plan's management of IS; rather, they determine whether the health plan's automated systems, information management practices, and data control procedures ensure that all information required for HEDIS reporting is adequately captured, translated, stored, analyzed, and reported.

The activities of auditors in this aspect of the audit consist of the following.

- Interviews of key plan representatives responsible for operations or departments supplying data used in HEDIS reporting
- Review of documentation relevant to IS standards and, as needed, demonstration of specific procedures
- Analysis of documentation describing the operation of computer systems and computerized files via text, code, and flow charts
- Observation of operations that includes areas that use IS resources while preparing data for the HEDIS report
- Verification of the accuracy of file contents
- Review of the plan's oversight of all data received and transmitted
- Evaluation of how data from the medical record review data abstraction process are integrated into the final measure calculations

(2) HEDIS Measure Determination Standards: Each measure has a detailed set of specifications that describes both its purpose and method of calculation. In this activity, auditors determine whether the processes used to produce each HEDIS measure comply with HEDIS specifications and yield reportable results. If issues or discrepancies are identified, the health plan is given the opportunity to make corrections and resubmit corrected code until the auditors are satisfied that all specifications are met. In this audit component, auditors evaluate the following.

- Identification of members for the eligible population (denominator) files, according to HEDIS specifications
- Determination of the extent to which sampling activities are performed according to HEDIS specifications
- Qualifying medical events (numerator) identification
- Determination of algorithmic compliance by ensuring that computation of HEDIS rates or percentages, as well as other parameters, is done correctly
- Documentation of data and processes
- Delegation and monitoring of activities performed by vendors
- Assessment of software precertification results, as applicable

Phase 3: Post-Onsite and Reporting Activities

In Phase 3, auditors work closely with plan representatives to ensure that they understand all unresolved issues and deficiencies, as well as the potential effects of these matters on HEDIS data collection and reporting. When appropriate, additional questions are presented to each plan about its software, programming, manual processing, and data input and output. Additionally, follow-up may become necessary to examine the effect of significant events, such as system conversion. Each plan is given a final review and the opportunity to correct unresolved items before a final determination on reportability is issued for each HEDIS measure. Key activities accomplished during this phase are as follows.

(1) Initial Report of Findings: Within 10 working days of the onsite visit, the audit team prepares an initial report on its visit. The report is returned to the health plan and includes the following components.

- A detailed list of any outstanding issues
- A list of all materials/documentation not yet received
- An assessment of whether each measure tested meets specific data requirements
- A list of all problem areas that require follow-up action before the final audit report is issued
- Potential problems with measure rate integrity
- Notes about any measures that, based on current findings, would receive a Not Report *(NR)* designation if no further action is taken to correct identified deficiencies

(2) Medical Record Review Validation: In this portion of the audit, auditors complete their evaluation of the health plan's medical record review process. They begin by reviewing all training materials and internal oversight policies established by the plan for medical record review. Next, auditors verify the accuracy of the health plan's findings in which a numerator-positive event was identified (i.e., the plan's reviewer determined whether or not the criteria for the measure were met and the designated medical service was delivered). Auditors select three measures for each plan and request 35 charts for each measure.

(3) DST Review: Health plans use the Data Submission Tool (DST) to electronically record all HEDIS results and calculations submitted to NCQA and MHCC. Maryland-specific data are submitted on an MHCC-specific DST. The DST review consists of two phases. First, the plan submits results to NCQA, where data are subjected to a series of rules and guidelines that help identify potential problem areas for correction. After passing this level of review, plans send the DST to the auditor for review. Auditors compare plan results to established NCQA benchmarks and the plan's rates from the previous year. Rates that vary by 10% or more between years are flagged, as are rates below the 10th and above the 90th percentiles, in comparison with NCQA benchmarks. Any problems detected are evaluated to determine whether additional analysis and review are necessary.

(4) Audit Designations: After reviewing all relevant documentation and processes, the auditor issues a designation of *Report (R)* or *Not Report (NR)* for each measure included in the audit. Determination for each measure is based on the rationales described here.

Report (R)

Report indicates that the measure is fully or substantially compliant with HEDIS specifications or has only minor deviations that do not significantly bias the reported rate. Under NCQA guidelines, it is possible for subcomponents of a measure to fail the audit and be designated *NR* without resulting in an *NR* rating for the entire measure. An example of this is the *Ambulatory Care* measure, which comprises four subcategories: outpatient visits, emergency room visits, ambulatory surgery, and observation room stays. One of these subcategories could be designated *NR,* but the measure, being a composite of three other reportable subcategories, would be deemed *R*. A measure designation of *R* may also be assigned where the denominator for the measure is too small to report a valid rate or where the plan did not offer a health benefit for the measure being reported. In these cases, the *rate* is designated in the Maryland publications as *Not Applicable (NA)*.

Not Report (NR)

In compliance with guidelines established by the State of Maryland, the *NR* designation indicates that the rate submitted by a plan did not pass the audit. In other words, the auditor determined that the results produced by the plan were significantly biased and did not reflect the plan's true performance. NCQA has broader categories for the *NR* designation, but in Maryland, health plans may not voluntarily choose to accept an *NR* designation in place of a rate. Plans are required to calculate and report all HEDIS measures that are part of the state's mandated performance-reporting process unless the measure is designated *NR* by the auditor.

(5) Audit Findings: HDC summarizes its audit findings in a plan-specific Final Audit Report that is submitted to the plan and to MHCC. The report includes recommendations for improvement and change in future audits.

APPENDIX D

METHODOLOGY FOR ADMINISTERING THE CAHPS® 3.0H SURVEY FOR MARYLAND HMOS AND POS PLANS

METHODOLOGY FOR ADMINISTERING THE CAHPS 3.0H SURVEY FOR MARYLAND HMOS AND POS PLANS

Background

The survey instrument and procedures employed in 2006 to obtain information about members' experiences with their health plans is the CAHPS[1] questionnaire and protocol. MHCC contracted with The Myers Group, an NCQA-certified survey vendor, specializing in health care and other consumer satisfaction surveys and, to conduct the research following standard CAHPS procedures. In addition, MHCC contracted with the NCQA-licensed audit firm, HealthcareData.com, to review programming code used to create the list of eligible members for the survey and validate the integrity of the sample frame before the certified survey vendor drew the sample and administered the survey. Survey data collection began in early February 2006 and lasted into May 2006. Summary-level data files generated by NCQA were distributed in June to each plan, to allow review of data prior to signing attestations.

Sample sizes remained stable in 2006, based on analysis of 2006 data. The sample size is set to achieve the minimum number (411) of completed surveys necessary to obtain reportable results.

In total, the Maryland core CAHPS survey consists of 62 questions and 8 Maryland-specific questions. The core of the CAHPS survey is a set of 10 measures used to understand satisfaction with the experience of care, which include four ratings questions that reflect overall satisfaction and six "composites" that summarize responses in key areas.

Ratings items ask respondents to rate their doctor, specialist, experience with all care, and health plan on a 0–10 scale. Responses are summarized into categories. Respondents who rate their physician 9 or 10 belong to the top category and those who rate their physician a 7 or 8 belong to the second.

Six composite scores are generated from individual respondent-level data: claims processing, courteous and helpful office staff, customer service, getting care quickly, getting needed care, and how well doctors communicate.

Survey Methods and Procedures

Sampling: Eligibility and Selection Procedures

Health plan members who are eligible to participate in the CAHPS 3.0H adult commercial survey had to be age 18 years or older as of December 31 of the measurement year (2005). They also had to be continuously enrolled in the commercial plan for at least 11 of the last 12 months of 2005, and be still enrolled in the plan in 2006. The data sets submitted to the CAHPS vendor are sets of all eligible members—the relevant population. All health plans are required to have their CAHPS data sets (sample frame) audited by the licensed HEDIS auditor prior to sending to the survey vendor.

[1] CAHPS originally stood for the *Consumer Assessment of Health Plans Study,* but as the products evolved beyond health plans, the name changed to *Consumer Assessment of Healthcare Providers and Systems* to capture the full range of survey products and tools.

After The Myers Group receives and checks the population sample from the plans, files are deduplicated to assure that no more than one member of a household is selected for participation, and then members are randomly selected.

The standard sample size for 2006 administration (2005 measurement year) was 1,100. To reach the maximum number of selected members, sample files were sent to a National Change of Address (NCOA) look-up and telephone matching service. Updated addresses and phone numbers were merged into the sample files.

Survey Protocol

The CAHPS survey protocol used to generate the data summarized in this report employs a rigorous, multistage contact protocol that features a mixed-mode methodology consisting of a four-wave mail (two questionnaires and two reminder postcards) with telephone follow-up of at least six telephone attempts. This protocol is designed both to maximize response rates and to give different types of responders a chance to reply to the survey in a way that they find comfortable. For example, telephone responders are more likely to be younger, male, and healthier; mail responders are more likely to be older, better educated, and less healthy. The mail-only methodology is an option under the CAHPS protocol, but MHCC chose to use the mixed-mode methodology.

Response Rates

As directed by NCQA, the response rate is calculated by dividing the number of completed surveys by the number in the original sample, minus the ineligible respondents (completes/total sample – ineligibles). A survey is classified as a valid completion if the member appropriately responds to Question 1 and answers at least 80% of the questions (not including *Medical Assistance with Smoking Cessation* or custom questions). Ineligible respondents are those who are no longer enrolled in the health plan, cannot respond to the survey in the language in which it is administered, are deceased, or are mentally or physically incapacitated.

There is no minimum required response rate; however, there is a required minimum denominator of 100 responses to achieve a reportable rate. In 2006, the average response rate of the seven plans was 38.4%, compared to 36.6% in 2005 and 39.0% in 2004. For 2006, the highest response rate was 47.0% and the lowest was 33.7%.